DOCUMENT RESUME

ED 371 845 PS 022 433

AUTHOR	Lejeune, Genevieve, Ed.
TITLE	AIDS: Children Too.
INSTITUTION	International Catholic Child Bureau, Inc., New York, NY.
REPORT NO	ISSN-0258-9648
PUB DATE	Mar 94
NOTE	77p.
AVAILABLE FROM	ICCB, Inc., 63 rue de Lausanne, CH-1202, Geneva, Switzerland ($13 for annual subscription).
PUB TYPE	Reports - Descriptive (141) -- Collected Works - Serials (022)
JOURNAL CIT	Children Worldwide; v20 n2 Mar 1993
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Acquired Immune Deficiency Syndrome; *Child Health; Children; Developed Nations; Developing Nations; Foreign Countries; International Organizations; Poverty; *Prevention; Program Descriptions; *Program Development; *World Problems
IDENTIFIERS	Africa; Brazil; Catholic Church; France; Italy; Nepal; Philippines; Prostitution; Rumania; Thailand; Uganda; United States

ABSTRACT

This journal issue is devoted to the many problems faced by children with Acquired Immune Deficiency Syndrome (AIDS) who live in both developing and developed countries. Section 1 provides general information on the pandemic, defining AIDS and exploring the social aspects of the disease. It also addresses child health, child mortality, moral and ethical concerns, and the Catholic Church's response to the pandemic. Section 2 contains short articles that examine pediatric AIDS in Uganda, Africa as a whole, Nepal, Romania, France, Switzerland, Italy, and the United States. Section 3 contains articles on groups of children vulnerable to contracting AIDS in the Philippines, Brazil, Thailand, and Nepal. Section 4 focuses on children who are orphaned due to the AIDS pandemic in Uganda, Rwanda, Italy, Brazil, and the United States. Section 5 focuses on AIDS prevention programs in Zambia, the Philippines, Zimbabwe, Hong Kong, and Chile, along with those developed by international organizations. (MDM)

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AIDS CHILDREN TOO

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VOL.20, Nº2-3/93
ISSN 0258-9648

Children *worldwide*

Children Worldwide is the international review of the ICCB serving its members and all those who work for the complete growth of the child.

Children Worldwide is published in French under the title **«L'Enfance dans le Monde»** and in Spanish (by the ICCB Secretariat in Montevideo) under the title **«La Infancia en el Mundo»**. It appears two times a year.

Articles may be reprinted provided a credit line such as «from International Catholic Child Bureau - Children Worldwide» is used. The ICCB General Secretariat in Geneva would appreciate copies of any publications in which Children Worldwide articles are reprinted. The opinions expressed in the articles are those of the authors.

Editor-in-Chief: Geneviève Lejeune

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Layout: Odile Conti

Photos: p.4-5 : CIRIC/A.Pinoges; p.7 : UNICEF/J.Hartley; p.10, 42, 48 : N.Labrador; p.14-15, 33, 51, 54, 56, 57,60 : B.Lecomte; p.20, 45, 53, 66 : CIRIC; p.24 : CIRIC/J.C.Gadmer; p.25 : WHO/Zafar; p.26 : Starcross Community; p.34 : CIRIC/L.Kervella; p.35, 37 : Caritas Manila; p.38, 40 : Clinica Ammor; p.39 : V.Guedes; p.59 : CIRIC/A.Szafran; p.64 : G.Musy; p.70 : J.Van der Rest.

Subscription rates* (Annual subscription)

- Europe, North America, Australia, New Zealand, Japan, South Africa:

SFR 30.—	FF 120.—	US$ 22.—

- Other countries:

SFR 18.—	FF 72.—	US$ 13.—

Payment : by cheque (SFR, US $) or by postal order (FF only), made out to the International Catholic Child Bureau, and sent to the ICCB General Secretariat in Geneva.

** ICCB members automatically receive Children Worldwide since the subscription is included in the membership fee.*

Edited by the ICCB : 63 rue de Lausanne - CH- 1202 Geneva, Switzerland - Tel. (41-22)731 32 48 - Fax (41-22)731 77 93

Contents

Introduction	• Millions of Children stricken by AIDS	3
General Information on the pandemic	• AIDS and Children - Dangers and Opportunities	4
	• Social Aspects of HIV/AIDS and Children	9
	• Children, Health and AIDS	11
	• Child Mortality through AIDS	13
	• Moral and Ethical Concerns	16
	• The Catholic Church's Response to the Pandemic of HIV/AIDS	18
Children with HIV/AIDS	• Uganda - TASO : Living Positively with AIDS	20
	• Perinatal Transmission of HIV in Africa	23
	• Nepal - A Potentially Explosive Situation	24
	• VIH Transmission and Breast-Feeding	25
	• Romania - A Family-type Alternative for Children with AIDS	26
	• France - Solidarity with Children Affected by AIDS	28
	• Switzerland - AIDS and Children Platform	29
	• Italy - Arché	29
	• United States - A System of Care for Families with AIDS	30
	• Talking to Children about HIV	33
Vulnerable Children	• Philippines - Street Children, Children at Risk	35
	• Brazil - A Clinic for Street Kids	38
	• Research on AIDS : Knowledge, Attitudes and Practices among Street Youth	41
	• Thailand - Sexually Exploited Children	43
	• Thailand - The Centre for Protection of Children's Rights	44
	• Nepal - A Cultural Prostitution	45
AIDS Orphans	• Uganda - Assistance Programme for AIDS Orphans	47
	• Rwanda - AIDS Orphans	52
	• Italy - A Home for AIDS Orphans	55
	• Brazil - The Children of the Day After	56
	• United States - AIDS and Families	58
Prevention	• Zambia : Anti-AIDS Clubs	60
	• Child-to-Child	66
	• Education for Life	67
	• Prevention at School Level	70
	• Chile - Educational Game	72
Bibliography		73

Millions of Children Stricken by AIDS

Such are the provisions of the World Health Organization faced with what some describe because of its nature as a curse unprecedented in the history of humanity.

This curse strikes children not only bodily when they themselves are contaminated by the virus, but also emotionally when AIDS deprives them of a father or mother, or often the two at once. Children who then find themselves head of the family or who are scattered - fraternity shattered - unless a grandparent takes them in. In Uganda, a grandmother brings up her 20 grandchildren on her own, her nine children and their spouses all having died of AIDS. This case is alas not an isolated one. In just one diocese in Uganda, 120,000 children are AIDS-orphans. Because of AIDS the number of orphans continues to rise, so much so that the wider family can no longer take on the responsibility. What will they become tomorrow? Many of them will have only the street as a solution...

A study carried out of 8,000 street children in São Paulo, Brazil, revealed that in 1990 more than 9% of them were already sero-positive. How many are there today?

The number of victims continues to rise. More than a million children are already infected at birth. Others have been contaminated by blood transfusions.

Almost everywhere in the world, men and women combine their efforts to alleviate the suffering of children with AIDS and those which it has made orphans. Others set up prevention programmes for young people.

By devoting this issue of Children Worldwide to children and AIDS, the ICCB wished to make known some of its many initiatives, with the aim of inciting new ones. This double issue has been prepared in close collaboration with Caritas Internationalis*, and its member organization from England and Wales, CAFOD. One of their major programmes, has for years, been devoted to the combat against AIDS.

The pandemic is relentlessly progressing throughout the world. The stakes are enormous. It must be the concern of everybody, at all levels, if we wish to preserve future generations and aid the children and youth of today, in those countries most cruelly afflicted, to continue to hope.

Geneviève Lejeune
Editor-in-Chief, Children Worldwide

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AIDS and Children

Dangers and Opportunities

Dr. Jonathan M. MANN*
Dr. Anne PETITGIRARD**

As the pandemic of human immunodeficiency virus (HIV) infection and AIDS increases worldwide, and as heterosexual transmission increases, the impact of the pandemic on children will inexorably expand and intensify. HIV/AIDS is already a major health problem for children in many areas of the world, and unfortunately, the direct and indirect effects on children will become much more important in the years to come.

Yet AIDS is more than a viral infection; it consistently raises fundamental questions in our personal and social lives, many of which are not new, but arise with unprecedented urgency in the context of HIV/AIDS prevention and care. Therefore, it is not surprising that the upsurge of HIV/AIDS among children has already, and will continue to challenge basic concepts about children.

For these two reasons - the increasing scope of HIV/AIDS among children worldwide, and the deeper meaning of the HIV/AIDS pandemic for children's lives - we believe that those concerned with the health and welfare of children in all countries must be fully informed about HIV/AIDS.

This article starts with an overview of the epidemiological situation worldwide, then focuses on HIV prevention and AIDS care from the viewpoint of the societal challenges arising in the pandemic. As the Chinese character for "crisis" contains within it the two distinct characters for "danger" and "opportunity", we will also seek to highlight the opportunities for advancing the health, welfare and rights of children which emerge in parallel with the clear dangers of AIDS.

The epidemiological situation worldwide

The global HIV/AIDS epidemic appears to have started in the mid-1970s; by 1980, an estimated 100,000 people worldwide had become HIV-infected. During the 1980s, the

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Caritas Internationalis

Founded in 1950, Caritas Internationalis is an international confederation of 125 autonomous national member organisations directed by its statutes to "spread charity and social justice in the world". This confederation was founded in Rome at the suggestion of Archbishop Giovanni Montini, then Vatican Sub-Secretary of State and later Pope Paul VI, who was deeply concerned with the mounting problems and needs of the postwar era and who wanted to ensure a Catholic presence in the field of relief, social welfare, and development. Caritas Internationalis was to have as its aims information, coordination, and representation of all Catholic-sponsored charitable and social service efforts. The independence of each member was underlined in a true spirit of democracy. These member organisations usually carry a mandate by their respective episcopal conferences to coordinate social welfare activities within their own countries.

Caritas Internationalis works **collaboratively with sister international Catholic humanitarian organisations** to share expertise and actions in a manner which eliminates duplication of effort and maximises effectiveness of efforts. Caritas collaborates with the International Catholic Child Bureau in raising attention about the needs and vulnerability of children and in promoting an active Church-based response to such problems.

Every four years, the national member organizations of Caritas Internationalis gather together in a General Assembly to make administrative decisions about the confederation, to share relevant experiences, and to reflect on the major social problems affecting the world and the Church at that particular time of history. In 1987, the participants in the Caritas General Assembly noted the profound impact which the pandemic of HIV/AIDS was exerting on all parts of the world, but most especially on countries of the South. For this reason, they selected **HIV/AIDS as a priority action** area for all Caritas member organizations and initiated a programme of education and service in response to the pandemic. The 1991 General Assembly of Caritas International decided once again to give a certain priority to this action area during the current four-year mandate.

pandemic expanded rapidly, reaching most countries and affecting a total of about 10 million people. By 1 January 1993, approximately 19.5 million people had become infected with HIV worldwide, of whom 18.3 million were adults (10.2 million men and 8.1 million women) and 1.2 million were children. The largest number of HIV-infected people are in sub-Saharan Africa (62 percent of the global total), followed by Southeast Asia (19 percent), Latin America and the Caribbean (8 percent) and North America (7 percent). Overall, nearly 90 percent of HIV-infected people live in the developing world.

The pandemic remains highly dynamic and volatile. HIV continues to spread in every community and country already affected (in the United States, from 120,000 to 240,000 new HIV infections are projected during the next three

years) and it is also spreading to new communities and countries. The HIV explosion in Southeast Asia now includes two million Indians, several hundred thousand Burmese and over one-half million Thais. Countries thus far little affected by the pandemic, including China, the Philippines, Indonesia, Bangladesh, Pakistan and Egypt, are likely to experience major HIV/AIDS epidemics in the next decade. Finally, according to the Global AIDS Policy Coalition (an independent research and analysis center based at the Harvard School of Public Health), between 38 and 110 million adults - plus at least 10 million children - will likely have been HIV-infected by the year 2000.

While many people still wrongly consider AIDS a "homosexual disease", heterosexual spread (from infected men to women and infected women to men) actually accounts for the large majority (71%) of all HIV infections worldwide. Globally, heterosexual transmission is responsible for about 90% of HIV infections among women. As of 1 January 1993, 13 million adults had acquired their HIV infection through heterosexual intercourse.

As the pandemic evolves, the role of heterosexual transmission has increased. For example, in the Caribbean, the HIV epidemic in the early 1980s was predominantly homosexual; today, the Caribbean HIV epidemic is dominated by heterosexual transmission. Worldwide, in the late 1980s, the male-to-female ratio of HIV infection was about 2:1; today, it is 1.25:1 and by the year 2000 it will almost certainly be 1:1.

HIV infections in children are closely linked with infections in women of childbearing age, as over 90% of HIV- infected children are exposed to HIV in utero, during childbirth or in the early post-natal period. As of 1 January 1993, 1.2 million children had become HIV infected, of whom the large majority (1 million, or 85 percent of the total) were in sub-Saharan Africa. In addition, over 100,000 HIV-infected children are in Southeast Asia, 55,000 in Latin America and the Caribbean, 15,000 in North America and 8,000 in Europe. Tragically, of these 1.2 million HIV-infected children, two-thirds (768,000) have already developed AIDS and at least 90 percent of these children with AIDS have died.

Within just three years (1 January 1996), the number of HIV-infected children will nearly double, to 2.3 million. By 1996, over 2 million children will have developed AIDS; this means that more children will become ill with AIDS during the current three-year period (1993-95) than developed AIDS during the

What is AIDS ?

AIDS is a disease which attacks the body's protective system. The body is unable to protects itself properly from other diseases such as diarrhoea, TB, coughs and sores in the mouth. With AIDS, these diseases make people very sick and they may even die.

AIDS may take 2-10 years to develop but the infected person can pass on the virus even if they show no signs of disease. AIDS is caused by a virus (Human-Immuno-deficiency Virus (HIV).

What does "AIDS" mean?

- **A - Acquired** means "to get". AIDS is acquired (or got) from other people who have the HIV.
- **I - Immune** means "protected". The body is normally immune (or protected) against many diseases.
- **D - Deficiency** means "a lack of". With AIDS, the body has a deficiency (or lack) of immunity against many diseases.
- **S - Syndrome** means "a group of different signs of a disease".

When people have AIDS they have a syndrome or many different signs of disease.

There are two main ways of getting AIDS. The HIV is transmitted:

- **By sexual intercourse** (vaginal or anal) with any infected person;
- **Blood-to-blood**, if someone receives blood containing the AIDS virus from another person:
  - by sharing needles or using unsterilised needles (for injections);
  - by transfusion in a hospital or clinic where the blood has not been properly tested;
  - by using unsterilised instruments that cut the skin (for circumcision, scarification, tattooing, ear-piercing, etc.);

However, unborn babies can also get the AIDS virus from their mother's blood during pregnancy.

Extract - Child-to-Child Activity Sheet on AIDS. Fore more details, see p.66.

entire history of the pandemic to date. Finally, for each child with AIDS, several children are orphaned by AIDS; the global total of AIDS orphans, now estimated at 2 million, will double to over four million by 1996. According to UNICEF, by the year 2000, from 6-11 percent of the children in 10 central and east African countries will have been orphaned by AIDS.

Prevention of the HIV

In summary, the epidemiological picture of HIV/AIDS in children is grim, for several reasons. First, the pandemic itself is expanding and accelerating worldwide, which increases the global danger. Second, the heterosexual component of the pandemic is increasing and the number of women affected is rising rapidly; the direct and indirect effects of the pandemic on children most closely follow the rates of HIV infection and AIDS among women. Third, progress towards a cure or a preventive vaccine remains slow. Fourth, the global response to AIDS is paradoxically decreasing despite the expanding pandemic, and it is marked by enormous inequity: for example, of the estimated 1.5 billion dollars (US) spent worldwide on HIV prevention in 1991, only 6 percent was for the developing world, where 90 percent of the HIV infections occur. Thus, compared with a per person expenditure of $2.70 for HIV prevention in North America in 1991, only $0.07 was spent per person in Africa and $0.03 per person in Latin America!

Yet beyond the epidemiological estimates and projections, we must try to see clearly the individual and societal realities of this pandemic. For the HIV/AIDS pandemic raises - in concrete and specific ways - fundamental questions about children, how they are seen by society, and therefore about their rights as human beings.

The social challenge of the AIDS pandemic

We can see how these issues are raised by considering several specific situations. First, in the

context of AIDS, children are considered by many to be "innocent victims", as they have become infected through their mothers. This rhetoric of blame, placing stigma on the mother on whom the child depends is not only wrong, but has had a paradoxical, negative effect on AIDS care for children. While in theory, being considered "innocent" and a "victim" should lead to increased care and support, children with AIDS are too often abandoned. One reason may involve the guilt of the parents, in some ways similar to the anguish which accompanies other chronic, fatal diseases of children. In addition, the parents of children with AIDS may be further stigmatized by the rhetoric of blame. Thus, although children with AIDS may be pitied, adequate resources are not made available for their care. This deprivation is "justified" on the basis of these children's poor prognosis, and is possible because of their lack of economic impact or political power. Thus, despite the high-sounding words AIDS once again reveals the enormous gap between what societies say about their children ("hope of the future", "our most valuable resource") and the realities of how resources are allocated on behalf of children.

The worldwide reality of sexual abuse of children must also be raised. Sexual abuse of girls and boys contributes directly to HIV/AIDS in children. Yet beyond immediate HIV transmission risks, the loss of socially valued virginity, the sale of children into the expanding market for satisfaction of adult sexual desires, and the devastating and lifelong psychological scarring which accompanies sexual abuse of children all contribute to increasing vulnerability to HIV infection. Sexual abuse in all its forms (from intrafamilial to outright prostitution) is an extremely painful problem, but it must be brought into the light of day.

A third example: to be effective, information and educational programs for HIV prevention must involve the "target population" (the audience) in their design and implementation. Yet programs for children and youth are often prepared and carried out by adults who assume they know what to say and how to deliver the message.

AIDS once again reveals the enormous gap between what societies say about their children and the realities of how resources are allocated on behalf of children.

The implicit assumption is that children and youth are not responsible enough to participate actively in prevention programs - they are merely supposed to obey and behave as directed by the adults.

In a similar manner, programs for street children and for AIDS orphans often underestimate these children's capacity to cope and even live independently, if necessary and critical support is provided. Thinking about orphans from the child's perspective might highlight needs not anticipated by adults, for whom the "placement" of an orphan in a household or an institution risks being seen as the solution. Who speaks for and from the child's viewpoint?

Thus, in many different ways, AIDS forces us to realize that society has an often ambivalent attitude about children and childhood: are children people, endowed with full rights as individual human beings, or are they chattel, the property of their parents?

Tragically, the societal inequality of children and the health impacts of this inferior status are magnified by the social inequality of their mothers. The vulnerability of women to HIV infection (and to inadequate AIDS care) is directly related to their role and status in society.

A global analysis of the pandemic and the response leads to a central insight: that societal discrimination (prejudice, stigmatization, inequality and injustice) is at the root of individual and community vulnerability to HIV/AIDS, as well as to other major health problems (injuries, cancers, heart disease, infectious diseases). The threat of AIDS to children's health and welfare is important: we must help prevent infection, and care for children with AIDS, the survivors of families damaged by AIDS, and all others affected by the pandemic. Yet our work must also reach beyond the individual child, household or community, to recognize and respond to the inextricable linkage between the health of children and the human rights and dignity of children. To put this understanding into concrete actions is our challenge: but the historic moment, the course of the HIV/AIDS pandemic and our commitment to children require no less. ❑

Social Aspects of HIV/AIDS and Children

Dorothy BLAKE*

By mid-1993, the World Health Organization estimated that some 14 million HIV infections had occurred cumulatively since the beginning of the epidemic. Of these 14 million infections 1 million or more have occurred in children.

In the vast majority of cases, these children were born to mothers infected with HIV, as transmission may occur in utero, or during or after birth (including breast feeding). Blood transfusion is a relatively infrequent and diminishing mode of transmission in children. But in certain countries sexual transmission in adolescents over 14 years (particularly girls) is increasingly being documented. Heterosexual transmission accounts for 75-80% of all transmission worldwide. Most of these infections have occurred in the developing world. Africa alone, with over 8 million infections and where transmission is almost always heterosexual, accounts for more than three quarters of HIV infection in children.

The social determinants and consequences of HIV in children are therefore related to HIV occurrence in adults, in mothers in particular, as well as to the role and status of children in society.

Developing countries are the most touched

With regard to social determinants, a striking feature of the AIDS epidemic is its more rapid increase in developing countries than in developed countries. Preexisting conditions which favour HIV/AIDS spread are: high levels of other sexually transmitted diseases, high levels of unprotected sex, shared needles among drug users, low educational levels, infrequent contact with health and social services, the low level of development of these services, denial and complacency concerning the magnitude and seriousness of the epidemic. Underlying all, poverty is a major contextual factor for HIV transmission. Poor communities not only have less access to information concerning HIV/AIDS, but are so caught up in the daily struggle for life at the most basic and essential level (food, water, shelter), that actions for HIV prevention rank low in the vital priorities.

Women are particularly vulnerable. Poverty in women is linked to and compounded by their low social/economic status in society and their burden of child rearing and family caring. To these social factors must be added the fact that HIV transmission is easier from male to female than vice versa. It is not surprising then that women, particularly young women in reproductive age, represent a group in which transmission is occurring fastest, nor that, as a consequence HIV infection in children is increasing. Therefore the rate of HIV transmission in children will increase in the foreseeable future. As AIDS is a fatal disease, on average 1 in 5 to 1 in 3 children born to an HIV positive parent will be infected, will develop AIDS, and die by their fifth year. The remaining uninfected children will have to grow up as orphans.

10 millions orphans by the year 2000

Indeed, a major social consequence of the epidemic is the large and growing number of AIDS

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orphans. It is expected that by the year 2000 there will be 10 million orphans worldwide, mainly in developing countries. For instance, in two districts in Tanzania, 65% of those orphaned of both parents are "AIDS Orphans". A child that has lost his/her mother or parents and is not attached to a caring adult is several times more vulnerable to childhood diseases, malnutrition and the psychological consequences of dysharmonious development. AIDS orphans, in addition to psychological and emotional distress of seeing their mother/parents die, are often forced to interrupt school education and look after the remaining family. These children, who are unprepared for the role they must assume, are likely to be abused and rejected, and many will respond to these pressures and responsibilities by trying their luck in the cities, where they are likely to join the growing numbers of street children.

There is an increase in direct HIV transmission in children fuelled largely by the parallel phenomenon of the growing number of street children who live and work in the streets because of poverty, abandonment, and absence of a caring environment. Street children are very early sexually active, and in many cases enter into male or female prostitution for survival or by force.

In some countries, girls are sold by their parents or relatives early into prostitution, often in illegal circuits where prevention programmes are difficult. Men with multiple partners go for younger and younger girls on the belief that they are free from HIV. Girls are sexually abused or enticed into "sugar-daddy" relationships in exchange for meals or little presents.

The cost of HIV infections, AIDS or orphan status children is inestimable in terms of death, suffering and dysfunctional development. The cost to society includes increased demands on social welfare services, and, more indirectly, the impact on overall development. As the epidemic impacts on infant and child mortality the favourable trend in these parameters seen over the last decade will decline. It is clear that strategies are needed that will focus, first of all, on prevention. This is the only weapon humanity has at present to avoid the negative human and social consequences of HIV/AIDS which will take generations to recover from, at a devastating human cost. ❑

In the countryside, AIDS orphans, left to fend for themselves, wander in search of food. They often go towards large towns where they swell the ranks of the street children.

Children, Health and AIDS

Sr. Maura O'DONOHUE*

HIV infection is predicted to become a major cause of sickness and death among children by the end of this decade. Yet at the beginning of the HIV/AIDS pandemic the threat posed to children and infants was not immediately apparent. However, with the passage of time it has become all too clear that infants and children are very much at risk.

Studies from around the world indicate various rates of HIV infection among infants born to HIV-infected mothers. In non-industrialised countries the rate of HIV-1 transmission from infected mother to her baby varies between 25% and 39%. In some industrialised countries the rate reported is as low as 12%. Paediatricians with experience of HIV-infection claim that the rate of transmission is probably much higher than statistics would indicate. Reports from WHO predict a looming child HIV epidemic by the end of this decade as a result of mother-to-child transmission.

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Transmission

Now that AIDS is firmly established in the heterosexual community it is certain that the number of infected infants and children will continue to increase. We are informed that 10 million children will have been infected with HIV by the end of this decade as a result of mother to child transmission. This transmission can take place during pregnancy, at birth or during breast feeding. Most of these children will be from developing countries, but there is also a growing problem in Europe and the United States of America.

Recent studies have shown a 26% transmission rate from mothers who were infected post-natally; and a 16% rate for those infected pre-natally. Infection rates do not seem to be related to the duration of breast feeding.

Children affected by HIV also include haemophiliacs who have been given HIV-infected blood products; or as has happened in Romania where underweight children were traditionally given micro blood transfusions.

Some concerns

- Considering clinical management there is first of all the question of diagnosis of HIV infection in children. HIV-related illness in a child may be the first indication that one or both parents may be infected. There is approximately a 30% chance that a pregnant HIV-positive woman will infect her baby. However, a child with HIV-antibodies is not necessarily infected with HIV as the child may in fact only be carrying the mother's HIV antibodies, and not HIV itself. Diagnosis of HIV/AIDS in children is more complex than in adults. In developing countries where the majority of children with AIDS occur, symptoms and signs of AIDS are quite similar to those of other common illnesses such as malaria, pneumonia, malnutrition, and diarrhoeal diseases. There are

difficulties in diagnosing because less developed countries do not have access to sophisticated technology required for identifying HIV infection in children. Even with laboratory facilities available, AIDS is difficult to confirm until the child is 12 to 18 months old. A relatively high proportion of HIV-infected infants present few or no symptoms during the first year of life. Others with HIV infection rapidly progress to AIDS, developing symptoms within the first few months. Some other children do not develop AIDS for 8 years or longer. This means that some children will be reaching the age of sexual maturity by the time they develop AIDS. WHO claimed that paediatric AIDS cases are infrequently reported.

- The **main indicator diseases** for AIDS in children are Pneumocystis carinii pneumonia (PCP), other bacterial chest infections, enlarged liver and spleen, and persistent oral candida on 2 occasions at least 1 month apart. The younger the age of the child when symptoms are present the worse the prognosis.

- For a **clinical definition** of AIDS the Bangui criteria are used. This definition includes major and minor signs. The major signs are - failure to thrive, chronic diarrhoea for more than 1 month, and oro-pharyngeal candida (thrush). The minor signs include chronic cough for more than 1 month, prolonged fever for over 1 month, generalised lymph gland enlargement and repeated common infections.

Caring for children with HIV/AIDS needs to be considered from aspects which are much wider than the purely clinical. These relate to psychological and social issues, stigma, the issues of confidentiality, education, breast feeding, vaccinations as well as clinical management.

- **Psychological and social factors**: A clinical diagnosis of AIDS in a child needs to be put in the context of others who may be affected. Some of the psychological and social factors include the stress and strain for the family members, especially the mother, frequent hospital visits with additional expenses; uncertain future for the child; guilt feelings on the part of parents; other siblings being denied necessary attention. But there is also very specific psychological stress for children who watch one parent die and then the second parent gets sick and dies from HIV-related illness. The oldest child is frequently left to take care of the siblings. We do not yet know the long-term effects of the psychological trauma for such child-headed families, where these same children face the prospects of raising their own children in similar circumstances.

- The issue of **confidentiality** is sensitive particularly when a child has reached school going age, or is being considered for adoption. Who has a right to information about the child's sero-status?

- **Childhood immunisations** are recommended to protect against infections, but it is now known that for the HIV-infected children they are less effective, e.g., measles vaccine gives lower protection although there are no adverse side effects. Polio vaccine can be given as the Killed Salk vaccine. BCG (to protect against TB) can be given prior to the onset of symptoms, e.g., at birth in most developing countries, but should not be given to HIV positive children.

- **Sexual abuse** of children, both within countries and by international tourists is a major area of concern. It is thought these children are exploited because they are presumed to be HIV-free. There is insufficient hard data available, however, on the number of children actually infected by HIV in this way.

- Many children are **orphaned** because of AIDS. By the year 2000 it is estimated that 50% of Ugandan children under the age of 15 will be orphans. This situation calls for urgent strategies to keep families together. ❑

"I worry continually what kind of generation we are going to have in my country when children are becoming the heads of household at 12 and 13 years old; when children watch their mum and dad suffer on a day to day basis; when children have to be separated after their parents have died and divided up between the relatives."

(Noerine Kaleeba, TASO, Uganda)

Child Mortality through AIDS

Peter KOK*

What can we expect in the coming years as far as child mortality caused by HIV infection is concerned ? Dr. Peter Kok has designed a model to calculate incidence, i.e., the number of new infections in a given year, which would be more or less equal to the number of children who will die from AIDS in the first 18 months of their life. The average mortality rate is in fact 18 months; it is higher in the United States and Europe, lower in Africa and Asia. The article explains how it is possible to calculate the incidence for a given town, region or country. It also brings out the grim perspectives for the future of children living in a world in which the behaviour of adults so directly and devastatingly influences millions of children.

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The impact of the HIV-epidemic on children is of increasing importance. It is true, at this stage, of the 13 million deaths in children each year, more are dying from malaria, respiratory and diarrhoeal diseases. AIDS will, however, take an increasing share of the infant and child mortality.

Child mortality due to AIDS will increase in two ways. Firstly, the direct effect on the infant of the virus obtained from its mother by vertical transmission (varying from 15-45%) and secondly, from the excess mortality due to diminishing care during the period of illness of its parents and once the child has become an orphan.

Estimation of the number of children condemned to die of AIDS

As the epidemic progresses, the cumulative figure of children having died of AIDS or HIV-infected, 1.2 million in 1993 and 2.3 million in 1995, will be mainly of historical interest. From the public health viewpoint, the number of children expected to die from AIDS is of more importance.

In many cities in sub-Saharan Africa the AIDS epidemic is well established and the maximum prevalence of HIV-infection in patients of antenatal clinics is nearly reached. Under these conditions the expected yearly variation in the number of infants and children to die from AIDS will be more or less stable. The short life expectancy of children born with HIV causes the child AIDS mortality to closely follow the epidemic of HIV-infection in the general population.

In the absence of other major routes of infection to the infant, the number of children infected with HIV will be related only to the HIV-infection rate of pregnant mothers, and the yearly number of children born in a particular community (indicated by the CBR-Crude birth rate).

Assuming the average vertical transmission rate to be 30%, possibly modified by breast-

Global Total of HIV Infections Now Over 15 Million

WHO figures show that the number of HIV infections since the start of the HIV/AIDS epidemic has topped 15 million worldwide. The largest number of new infections has been in Africa, where the cumulative total is now close to 10 million - an increase of 1.5 million over the last year.

During the VIII International Conference on AIDS in Africa, Dr Michael Merson, Executive Director of the World Health Organization, Global Programme on AIDS said:

"The news on the epidemic is not good. Since the last AIDS in Africa Conference in Yaoundé only a year ago, some two million more men, women and children worldwide have been infected with HIV, most of them in Africa. Although Central and East Africa remain hardest hit, the virus continues to spread north, west and south. To the north, Ethiopia reports, with great openness, that it has close to half a million infected people. To the west, prevalence rates in Nigeria have reached as high as 22% amongst men attending STD (Sexually Transmitted Diseases) clinics. And to the south, where we think the epidemic may take its greatest toll, already more than one in three women seeking antenatal care in Francistown, Botswana, are infected."

According to Dr Merson, the spread of HIV is being encouraged by migration, population displacement due to civil strife and other movements of people. But the African epidemic is also being driven by a rising tide of infections among adolescents and young adults, especially where the epidemic began early:

"A new WHO analysis of these so-called "mature" epidemics in such countries shows that 60% of new HIV infections are among 15-24 year olds. This demonstrates the vulnerability of Africa's youth - and shows us where to focus our prevention efforts. At the same time, we urgently need to prevent transmission of HIV to women. By the year 2000, unless we manage to reduce their vulnerability, some 5.5 million African women will have been infected."

Creative AIDS campaigns

"Africa has developed magnificent models of prevention and care, but these are not yet being replicated widely enough, well enough or fast enough. Every section of society must be involved - including people with HIV or AIDS, who must be welcomed as partners in this effort. And the commitment must start at the top. No doubt top-level political commitment does exist in some African countries. And some countries are putting impressive resources into the fight. But too many others are lagging behind in both commitment and resources."

In the past year alone, half a million Africans have developed AIDS. The consequences for the continent are already enormous. The impact is most acute in individual households, especially where more than one adult has died of AIDS. In large urban hospitals in countries such as Burundi and Rwanda, more than half of the adult beds are occupied by AIDS patients. In many African countries, the annual number of tuberculosis cases has doubled or even tripled. Mortality among Zambian nurses has doubled. Over 9 million African children will have been orphaned in this decade alone.

World Health Organization, Press Release WHO/101/10 December 1993.

feeding patterns, one can derive the estimated number of children that will die annually from AIDS per million population in any country.

For example for sub-Saharan Africa with 500 million people of which 20% will be urban and 80% rural with an average HIV infection rate for those who attend prenatal consultations of 10% and 5% respectively, and an average crude birth rate of 40/1000, the resulting annual number of children with AIDS will be:

20% urban = 100 million people x 1200 = 120,000 children HIV-positive

80% rural = 400 million people x 600 = 240,000 children HIV-positive.

The total expected number of children born with a HIV infection will be 360,000 per year under the reasonably assumed conditions. Under stable epidemic conditions, this number will be an approximate fit for the annual number of children subsequently dying from AIDS.

Under sub-Saharan conditions of an average Infant Mortality Rate (IMR) of around 100/1000 births, the additional IMR on account of AIDS will be 3=/1000 for the urban area and 15/1000 for the rural area. The excess mortality in children from affected families from other causes may be estimated at a third of the direct AIDS associated mortality, adding another 120.000 deaths. The total AIDS-related death burden on sub-Saharan Africa may therefore be near to 480.000 annually, or roughly 30 to 40% of all deaths in children.

Major increases in infant and child AIDS-related mortality will still happen in rural sub-Saharan Africa and in Southeast Asia.

The rapid spread of the HIV epidemic in the Asian region is facilitated by a generally low social status and literacy rate of women, extensive poverty and a sluggish reaction of governments towards control measures. It is expected that in Asia more so than in Africa, HIV-related child mortality will be a major cause of child mortality. The large Asian population progressively becoming affected by HIV will result in very high numbers of AIDS-related deaths, even when taking into account that the CBR in these regions is lower than in Africa.

Should the present trend continue, it can be calculated that at a 5% infection rate among women in urban areas (40% of the population) in Southeast Asia, one can expect 2.4 million children annually dying from AIDS. Will it take 10 or 15 years to reach that stage?

Given the high mortality rate (20-80%), especially in Africa, of infants who are not breast-fed, the advice remains that HIV-positive mothers continue to breast feed their infants. ❑

Child mortality due to AIDS will increase in two ways. Firstly, the direct effect on the infant of the virus obtained from its mother by vertical transmission (varying from 15-45%) and secondly, from the excess mortality due to diminishing care during the period of illness of its parents and once the child has become an orphan.

Moral and Ethical Concerns

Fr. Enda Mc DONAGH*

A world crisis and its harrowing and heroic stories of human suffering require Christian response and reflection and some fresh theological consideration. The HIV/AIDS crisis has some distinctive characteristics beyond its global range and savage suddenness, as it brings together in such devastating mix the great powers of sex and death.

Jesus and his God are not to be understood simply in terms of the passion and death on Calvary. These undoubtedly form the climax to his life and mission as they do to the Gospel narratives. Yet they are only properly and fully understood in the light of Jesus' public life and ministry by which he pursued his mission and encountered his destiny. By the announcement of the kingdom or reign of God which opened the ministry and specified the mission, Jesus at once confirmed and transformed the tradition of Israel.

This is not a kingdom first of all for the powerful and wealthy, who were toppled from their seats and sent empty away. The sinners and the prostitutes, the poor and the socially marginalised like the lepers and the tax collectors would go first into the kingdom. By identifying with them, by eating and drinking with them Jesus overturned the accepted canons of religious and political respectability. It was eventually to cost him his life as he was considered too subversive of the established order and after a show trial was crucified between two other criminals outside the gates of the city.

It is only the community of Jesus' disciples who can explicitly recognise and consciously respond to the call to proclaim and promote the kingdom. But the kingdom is for all human beings and above all by Jesus' example and teaching for the least of our human sisters and brothers, meaning the least by the standards of the worldly world, the poor, the socially excluded, the sick, who in a time and place of AIDS can so easily coincide. So the disciples of Jesus, as entrusted with the vision and enabling call of the kingdom, must offer a lead in responding to these last ones by active caring, loving personal relationships, and structural reform.

A range of values : truth, freedom, justice and peace

Within the biblical-theological tradition, it is possible to discern a range of values which are to be realised in the presence and through the power of God. The four kingdom values which seem to serve these theological and philosophical purposes are those of truth, freedom, justice and peace (shalom).

Social and personal crises like war and the pandemic of HIV/AIDS threaten TRUTH. At least without continuous commitment of truth, the crisis will be misunderstood and the responses mistaken. The temptation to conceal the truth of the extent of the pandemic is one aspect of how the threat may aggravate the crisis. Fear of contagion by family, friends and carers based on untruth can readily undermine social and personal responses. Only the truth in the Gospel phrase will set us free to deal effectively with the crisis. And it is the divinely begotten hunger for truth which may hope through research to find medical means of protection and cure.

In the face of the pandemic the search for FREEDOM from further infection through effective and humane preventive measures is an essential response to the kingdom call. Development of therapeutic measures connects the kingdom call to truth and its call to free people from the slavery of disease. Programmes of mandatory testing for so-called "risk groups" or of quarantine for people with HIV/AIDS are usually unfair restriction of those already restricted socially or physically. Here the cross-over between freedom and justice emerges in human rights or liberties. In quite a different manner freedom and

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maturity emerge for the sexually active as forming the basis for the integration of sexuality into personal maturity in relating to other sexual beings.

Many of the problems revealed by the pandemic are problems of JUSTICE, personal and social. Some of these may be adequately expressed in terms of human rights and pursued in that fashion. However not all delicate justice problems may be translated into human rights language without considerable loss of moral impact.

The HIV/AIDS pandemic should stimulate a much-needed development in understanding and promoting the kingdom value of PEACE. The dimensions of solidarity, healing, reconciling and forgiving have obvious relevance for both the personal and social challenges of HIV/AIDS. Their understanding and application here will provide insight into other peace needs and possibilities.

Unconditional acceptance

Jesus' recognition and inclusion, to the point of table-fellowship, of the poor and excluded provides the model for Christian ministry to people with HIV/AIDS. The first moral response of disciples must be to accompany the ill and infected. Without unconditional acceptance and persistent accompaniment the most skilful professional care, moral analysis and education will lack Christian authenticity.

The time of AIDS is far from over. Theology remains permanently unfinished. This essay, too brief to do justice to the many aspects of theology touched by the pandemic, may alert and enlighten some as to the threat the whole human and Christian community faces. ❑

Human Rights in the face of HIV/AIDS

When the subject of human rights is evoked, most often one thinks of beautifully-worded documents prepared by some United Nations body or by some other intergovernmental or international organization. Some of the specific rights which have vital significance to persons affected by HIV/AIDS are the following:

- the right to life, liberty, and security of person;
- the right to health protection;
- freedom from inhumanity or degrading treatment or punishment;
- the right to freedom of movement;
- the right to work;
- the right to privacy and to receive information;
- the right to marry and found a family;
- the right to education;
- the right to social security assistance and welfare.

Sadly it must be reported that the above-mentioned rights are frequently abused in the case of persons who are living with HIV or AIDS. Every day and in all parts of the world, such persons face discrimination and social rejection. Some forms of discrimination against those affected by the pandemic include:

- quarantine
- housing discrimination
- impediments to receiving health care
- discrimination in the workplace
- interference with the right to education
- restrictions on the freedom of movement
- compulsory screening/testing for HIV.

Women and children have been special targets for bias and prejudice against those effected by AIDS. A combination of biological and social factors make them more vulnerable to the transmission of HIV, yet they are frequently excluded from prevention, care, and research programmes.

History should have taught us that repressive and discriminatory measures have never been effective in controlling an epidemic. Thus Dr. Dorothy Blake, of the World Health Organization Global Programme on AIDS, has declared: *"The human rights of people with HIV must be respected, as this is one of the best means of safeguarding the health of all people in each and every country. Discriminatory measures... undermine public health efforts to control the disease, because stigmatization can drive those people who would benefit from counselling and medical care underground."*

"Human Rights and AIDS Discrimination Impedes Fights Against AIDS", Press Release WHO/48, 22 June 1993.

The Catholic Church's Response to the Pandemic of HIV/AIDS

Fr. Robert J. VITILLO*

As with so many other human challenges and crises, both individual members and the organizational structures of the Catholic Church have been actively responding to the pandemic of HIV/AIDS during the course of the last decade. The basis of such actions could be found in the threefold mission of the Church: TEACHING, SERVING, AND GATHERING PEOPLE IN WORSHIP.

Teaching

Perhaps the first and, to date, the loudest response of the Catholic Church to the pandemic has come from its role as TEACHER. One after another, Conferences of Catholic Bishops have utilised the onset of HIV/AIDS as an occasion to reinforce traditional moral teachings and values, especially with regard to sexual behaviour and marital relationships.

The teaching role of the Church, however, goes far beyond lessons in sexual ethics and moral theology. Thus, Catholics have been called upon to shape their response to AIDS in accord with the literal, or Greek, meaning of their Church's name, whereby "Catholic" means "universal". Thus Pope John Paul II declared during his visit to San Francisco in September:

"...the challenge is to love as God loves us, without distinction, without limit, for he loves those of you who are sick, those suffering AIDS." [1]

Serving

The second aspect of the mission which Christ entrusted to the Church is that of SERVICE or DIAKONIA. Church leaders have expanded the vision of Church-related HIV/AIDS services far beyond that of providing health care to a whole range of social and pastoral activities. So the Catholic bishops of Australia wrote:

"From our Catholic community, we speak of a ministry of spiritual and practical assistance to all AIDS patients, and their families, and friends. We anticipate that every parish will soon be touched by AIDS in the same way, through individual suffers, or their families and friends." [2]

Caritas Internationalis has been privileged to participate in this aspect of the Church's response to AIDS. This confederation counts among its members the national Catholic social service and development organizations in 145 countries of the world. Caritas has sponsored educational and awareness-raising seminars for Church leaders and other health and social service professionals on regional, national, and local levels. Within the Caritas network, and with the special assistance of the English Caritas member organization, the Catholic Fund for Overseas Development, which serves as liaison agency for AIDS programmes, several million dollars are raised each year to support service programmes in Africa, Latin America, Eastern and Central Europe, Asia and Oceania. The projects include expansion of medical and social service

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facilities: supply of food, medicines, and HIV-antibody testing equipment; staffing and transportation for mobile home care programmes; support for residences for homeless persons with AIDS, for development-oriented orphan care programmes, and for alternative income-generating projects for commercial sex workers. Caritas Internationalis has been especially effective in promoting North-South and South-South experience exchanges and networking among AIDS-service providers.

A listing of such service programmes could never adequately capture the vitality and dedication of those countless individuals (many of whom are HIV-infected themselves) who are giving much but perhaps are receiving more as they reach out in Christ's name to alleviate suffering and to bring hope to those whose lives have been so deeply impacted by HIV and AIDS. I am thinking especially of an Afro-American sister who works with persons with HIV/AIDS in the slums of Nairobi, of a Catholic laywomen who visits prisoners with AIDS in the jails of São Paulo, of a group of very traditional sisters who pray in their chapel by day and then work on the streets of Santo Domingo by night to assist commercial sex workers who are in need, of a priest in Northern Thailand who has developed a farming cooperative to assist families who would otherwise be forced to sell their young daughters into commercial sex work in order to survive.

Gather People in Worship

In the third aspect of its mission, the Church is called upon to GATHER PEOPLE IN WORSHIP in order to deepen their relationship with God on their journey through life. We might say that the Church is indeed unique in its ability to assist or accompany persons with HIV/AIDS in confronting the final realities of life.

In spite of their inability to find the right words to say to a young man or woman who is dying of AIDS and of their own fears and lack of knowledge about the pandemic, pastoral ministers are indeed offering spiritual accompaniment to persons with HIV/AIDS. I will never forget one experience when I accompanied Sr. Ursula Sharpe of Kitovu Hospital, Masaka, Uganda, on a home visit to an old, Muslim man who was suffering from AIDS and had already lost several wives and children to the disease. After we had exchanged conversation and Sr. Ursula had applied some soothing ointment on his itching sores, he asked us to pray with him, and, at that moment, all separations between North and South, between men and women, between black and white, between Muslim and Christian, were transcended and we were all embraced and comforted in the oneness of God.

The impact of HIV/AIDS on families and children poses new demands and challenges to members of the Church and to all persons of good will. How will we respond as individuals and as believing communities? Let us pray that the guidelines articulated by the bishops of the United States will become a reality throughout the world: *"Our response to the needs of persons with AIDS will be judged when we discover God in them and when they through their encounter with us, are able to say, "In my pain, fear, and alienation, I have felt in your presence a God of strength, love and solidarity".*"[3] ❑

Adolescents : pave a way for trust and hope

New questions about life, death and love are preoccupying young people on the threshold of adolescence. For adolescents, the AIDS epidemic has brought with it a multitude of questions and a burden of anxiety. Where are the answers to be found? Without denying the importance of all the explanations and advice circulating in society at the moment, the voices of Christians can express words which contain deeper and more far-reaching truths. For instance the words of Christ, spreading the news of God's plan. God who lovingly created humankind, men and women, and whose tenderness is not extinguished by any moral or physical evils. He does not wish anyone to be lost. His Word paves the way for trust and hope - the path to true happiness.

His Word can be heard by listening and remaining vigilant.

Olivier De Dinechin, S.J. - Pastoral letter for priests and educators - "Documentation Catholique", Paris, 6 June 1993, N° 2073.

[1] Pope John Paul II, Address to Catholic Health Association, Phoenix, Arizona, USA, September 1988

[2] Bishops of Australia, The AIDS Crisis, 20 May 1987

[3] United States Catholic Conference Administrative Board, "The Many Faces of AIDS: A Gospel Response", 24 December 1987.

Uganda

TASO : Living Positively with AIDS

Janie HAMPTON*

The AIDS Support Organization (TASO) is the first organized community response to the AIDS epidemic in Uganda. Founded by a group of volunteers in late 1987. TASO now provides counselling, AIDS information, nursing care, educational support and material assistance to about 5,500 people with HIV or AIDS and their families. Many TASO workers are themselves people with HIV or AIDS.

The first cases of AIDS in Uganda were reported in 1982. Since then the number of cases reported has increased enormously. By December 1990 nearly 22,000 cases had been reported to the national AIDS Control Programme, but these were only a small fraction of the total.

The number of people infected with HIV is many times greater than the number of AIDS cases. The Ugandan AIDS Control Programme has estimated that 1.3 million people were HIV-positive in late 1990.

In Uganda, as elsewhere in Africa, transmission of HIV is mainly through heterosexual intercourse and from mother to unborn child. Men and women are affected in equal numbers. AIDS in Uganda affects all members of the family - either directly or indirectly. (In the industrialised world, AIDS affects mainly single people.) The age distribution of people diagnosed HIV-positive shows that the majority (80%) occur between 16 to 40 years, with 10% in the 0 to 5 years age group. Virtually no children between 6 and 15 years of age are HIV-positive.

For the people of Uganda, AIDS is part of a cumulative catastrophe. The country's economy and social infrastructure are only just beginning to recover from nearly 20 traumatic years of civil war and unrest. Hospitals and health centres are run-down and essential drugs and equipment are in short supply or non-existent. Many health professionals have either left the country or taken other jobs because their salaries were so low. There is, for example, only one doctor for every 23,000 people.

Origins of TASO

TASO has its origins in a small group of people who began meeting in one another's homes in Kampala in October 1986. All but one had HIV or AIDS. They met to exchange information, to give each other sup-

* Excerpts from "Living Positively with AIDS - The AIDS Support Organisation (TASO), Uganda", by Janie Hampton, Strategies for Hope N° 2, 1990.

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port and encouragement and to pray.

When TASO was formally established in November 1987, the group consisted of seventeen people, including twelve who had HIV or AIDS (all of whom have since died).

The founding members of TASO had no training in counselling or experience of managing an AIDS support group. There were no precedents for such groups in Africa from which they could learn. They had no office, no transport and no funds. But what they did have was initiative, vision and a deep commitment to practical action on behalf of people with HIV and AIDS, who were neglected by the health services and ostracized by the rest of society. It was this combination which persuaded two British organizations - ActionAid and World in Need - to provide TASO with the funds to get started.

ActionAid also arranged for two founding members of TASO to participate in a one-week training course for AIDS counsellors in London.

All those involved in starting TASO were practising Christians who regularly prayed together, but they made a conscious decision to make TASO a non-religious organization.

Although TASO is a non-governmental organization, another key factor in its establishment was the open and constructive attitude of the Ugandan Government.

Children's clinic

An AIDS clinic for children is held every Friday morning at Mulago Hospital in Kampala. Most of the children are babies or toddlers. Babies infected with HIV develop AIDS more quickly than adults. Few survive beyond the age of two years, and many die before being diagnosed as having AIDS. Most die within a year of birth, often of dehydration or

Community Programme

TASO began a community outreach programme in September 1990. Responding to requests by clients.* The programme's objectives include the provision of AIDS education, the promotion of positive attitudes towards people with AIDS or HIV, home care of people with AIDS, a referral system and the support of community efforts to alleviate the socio-economic consequences of AIDS.

The TASO programme has received many requests from communities for training.

TASO trains a local AIDS committee to oversee and plan AIDS activities. TASO community workers are volunteers selected by the community and trained as AIDS resource people. Drama, dance and song are used extensively for community education. Some communities have already started income-generating projects to support clients, orphans and AIDS education activities.

TASO Community Programme courses

The four courses for the Community Programme are:

1. One-day Community Education Seminars for all community members who participate in discussions and education about AIDS, stimulated by drama and songs.

2. One-day Community AIDS Mobilization Workshop for up to 50 community leaders. This covers facts about HIV and AIDS and the impact of AIDS on the community, and should lead to a community action plan for responding to AIDS.

3. The TASO Community Worker Training Course lasts for five days followed by in-service training one day a month. Mature volunteers must be chosen by the community and have a positive attitude towards people with HIV and AIDS. The course covers basic facts, home care, attitudes, skills and referrals. TASO community workers can then educate others and practice home care, AIDS prevention and referral.

4. The TASO Community Training of Trainers Course runs for 14 days followed by in-service training one day every two months. The trainers must have community-based experience, and a background in social work, health or education. The course teaches them basic counselling skills, how to initiate and manage a community AIDS programme (including income-generating projects), how to design training activities and support community efforts.

* At TASO the word "AIDS" is rarely used. People with HIV or AIDS are described as being "body-positive". They are referred to as "clients", never as "AIDS victims" or "AIDS suffers". The term "patient" is used only if a client is admitted to hospital. TASO is also sensitive to words like "catastrophe", "plague" and press statements such as "This person is going to die".

malnutrition due to repeated diarrhoea and other infections. Many are not brought to the AIDS clinic until they are already close to death.

TASO counsellors talk with mothers as they sit on a low wall, suckling their babies before seeing the doctor. The nurse calls the mothers into a small room where the doctor sits close to them. She asks the mother how the baby is and examines the baby gently, feeling for swollen lymph nodes, listening to the chest, and looking in the mouth for thrush. Many babies require antibiotics for chest infections, others are given oral rehydration salts for diarrhoea. Whenever the drugs run out, TASO provides whatever it can until the hospital's supplies are replenished.

Blood tests are usually necessary to diagnose HIV infection in babies and young children because the symptoms of AIDS in young children are similar to many other children's diseases. But taking blood often involves a struggle. Doctors and nurses may have to take blood without the protection of rubber gloves simply because there are not enough gloves available.

All the mothers of babies and young children with AIDS are themselves HIV-positive. They may discover this only when the babies are diagnosed. ❑

For more information: TASO, P.O. Box 676, Kampala, Uganda.

The Fight against AIDS in the Socio-Cultural Context of Africa

On the occasion of the World Day of AIDS Prevention, a Zairian Commission met (November 1992) in Kinshasa (Zaire), to study the extent of the ravages caused by the disease in the country and envisage ways of fighting and preventing it. Below, is an extract from the intervention by Mgr. Patient Kanyamachumbi, General Secretary of the Bishops' Conference of Zaire.

"Among the hard realities of the end of this XXth century, we must count the devastating scourge of AIDS. It is a grave danger for all men and for all the peoples of the world. But, it seems, the Africans are more vulnerable today and, because of this, more numerous among those who are certain to be AIDS victims. It is calculated that the Africans who have AIDS represent a quarter of all those who have AIDS in the world. This situation challenges all and demands an appropriate attitude and response.

Why, in Africa, and in Zaire in particular, are we more vulnerable and why do we offer less resistance to AIDS than other people's of the world?

While awaiting answers from experts, a careful look at our general conditions of life shows that, for us, the greater danger is perhaps not the AIDS virus as such, but the socio-cultural context in which it finds us.

As long as we continue to die by thousands of illnesses against which medicines exist and are available everywhere else in the world, who can honestly promise to protect us effectively against illnesses as dangerous and as incurable as AIDS?

If we are not even capable of reaching agreement among ourselves on the setting-up of the rule of law in our country and thus be able to fight against ignorance, incurable diseases and famine, then what chance do we have of one day winning the battle against AIDS?

As long as public health is unorganised and many of our compatriots continue to suffer and to die in great numbers from illnesses which other populations have already overcome, what resistance can we put up against AIDS?

No, the Africans, and the people of Zaire in particular, do not die of AIDS because they are less disciplined in their moral conduct, nor because their body structure is more fragile, but because they lack an efficient community structure capable of stimulating, organising and managing our solidarity and generosity within a just and caring State (...) AIDS is a global evil. It can only be mastered by greater charity and greater solidarity."

Excerpt from "La Documentation Catholique", No. 2067, 7 March 1993.

Perinatal Transmission of HIV in Africa

In 1982, just a few months after the initial description of AIDS as a new adult disease, several cases of AIDS were reported among children by different US and European teams. These AIDS cases brought to light one of the most tragic aspects of HIV infection: the transmission from mother to child. Although it is known that not all women carrying HIV pass it on to their children, the risk of infection and the intimate mechanisms and factors affecting it are not yet well known, partly because of the problem of early diagnosis of the infection in children. However, we now know more about when the infection occurs.

With a view to taking action to stop the perinatal transmission of HIV in mothers during pregnancy and/or in very young children, it is essential to know the exact time of contamination. The foetus has receptors very early on which permit the penetration of cells by HIV, and a number of studies have shown that it can be infected at 8 weeks of gestation. The exact frequency of early contamination is not known, however. Antenatal diagnosis is not possible because of the risk of direct contamination of the foetus during the actual procedure. A diagnosis on the product of abortions has been attempted. The possibility of contamination by the mother's cells is difficult to rule out, especially since the methods of detection used are as sensitive as PCR*.

A number of teams have studied the state of the placenta and membranes to support the hypothesis of transmission via the placenta. A significant increase in chorioamniotes in HIV-positive women was observed and placenta cells were found to be infected by HIV in anatomo-pathological samples. But the absence of the virus in the embryo-foetus and the low level of sensitivity of PCRs and cultures in blood from the umbilical cord would seem to indicate that the foetus is infected relatively late in the course of gestation.

Infection during labour or birth

In fact, a large proportion of non-contaminated children are probably infected during labour or birth.

Studies on pregnancies involving twins have shown that the first-born is much more often infected than the second, which suggests that the infection occurs late in pregnancy because of proximity to the cervix (upwards) or transmission at the time of birth, as the first twin is exposed to a more difficult labour than the second one. A comparison of the results of viral cultures, PCR and antibody profiles produced on samples taken close to birth and in the weeks afterwards have enabled primary infection to be dated in infants. Thus in the French multicentred study, around 60% of the children infected in the perinatal period were probably infected during birth.

It is difficult to assess the question of transmission by breastfeeding in children exposed to HIV throughout pregnancy and at the time of birth. The two French and European multicentred studies demonstrate, however, that there is a risk of transmission from mother to child during breastfeeding. However, over half of the children breastfed by their mothers will not be infected. The risks and advantages of breastfeeding by mothers should be weighed up carefully. The risk of postnatal transmission must be very high to counterbalance the well-known high death rate among bottle-fed children in developing countries. The WHO recommends that HIV-positive mothers should breastfeed if risk-free bottle-feeding cannot be guaranteed. ❑

* Polymerase Chain Reaction: very specific and sensitive biological tests permitting the direct detection of the virus in the blood by means of a culture or by highlighting viral ADN in the lymphocytes.

Sophie Lallemant-le-Coeur, Harvard School of Public Health, Boston (USA), Samuel Nzingoula, Directorate of Mother and Child Health, Brazzaville (Congo), Marc Lallemant, ORSTOM, Brazzaville (Congo); extracts from the review «SIDAFRIQUE» (OPALS newsletter), N° 1/93.

Nepal

A Potentially Explosive Situation

Asnish GURUNG*

The children of Nepal are no more angelic that the children of any other country in the world. Of course, since the country itself is one of the least developed countries, the children somehow are made victims of all the humiliations that a poor country has to face. Nepal is basically an agricultural country with 90% of the population engaged in agriculture. Hence, we have rural children and urban children. The rural children are deprived of all the modern amenities and facilities that the urban children enjoy. Among the rural population, a girl child has a low priority in the family. The boy child gets all the preferences. Usually the girl child is not sent to school. However, in the urban areas, the picture is changing - girls are treated the same as boys. Again, the stories of urban children, especially from poor families, are of a completely different nature. There are about 150,000 who work in the carpet factories in the most unhygienic conditions. 52.71% of these children are illiterate and 47.29% are drop-outs. Their ages range from 7 to 16 years. Many children are employed as domestic servants as well as dishwashers in the teashops and restaurants. Many are eking out their existence as rag-pickers. Apart from these child labourers and rag-pickers, there are many fortunate children in the urban areas who do enjoy what the cities of an underdeveloped country have to offer. The main thing is that there are many schools which are almost always full to capacity.

As regards AIDS, it has not yet become a pandemic in Nepal but it may explode like a volcano when one least expects it! We have a government-run agency called AIDS Prevention and Control Programme and there are about 50 NGOs who in some way or other collaborate with work for people with AIDS or who are HIV-positive. Caritas works with two of the NGOs who are involved with the mass education programme on AIDS, in prevention and the rehabilitation of the HIV-positive women. According to the government statistics there are only 133 identified HIV-positive cases but according to the World Health Organization there are around 10,000 people in Nepal who suffer from this deadly disease. The main reason for the spread of this disease is that thousands of Nepalese girls who have been sold to the brothels of Bombay, Calcutta and other parts of India regularly come back to Nepal either to visit their families or to stay. Also thousands of men go to other countries in search of jobs and when they return some of them may bring along the unwelcome guest (the virus) with them. The people, rural as well as urban, are being made aware of AIDS and HIV through various media. ❑

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VIH Transmission and Breast-Feeding

In view of the importance of breast milk and breast-feeding for the health of infants and young children, the increasing prevalence of HIV infection around the world, and recent data concerning HIV transmission through breast milk, a Consultation on HIV Transmission and Breast-feeding was held by WHO and UNICEF (May 1992) at which recommendations on breast-feeding were formulated. Here are some of the main extracts:

Based on the various studies conducted to date, roughly one-third of the babies born worldwide to HIV-infected women become infected themselves, with this rate varying widely in different populations. Much of this mother-to-infant transmission occurs during pregnancy and delivery, and recent data confirm that some occurs through breast-feeding. However, the large majority of babies breast-fed by HIV-infected mothers do not become infected through breast milk. Recent evidence suggests that the risk of HIV transmission through breast-feeding:

- is substantial among women who become infected during the breast-feeding period, and
- is lower among women already infected at the time of delivery.

However, further research is needed to quantify the risk of HIV transmission through breast-feeding and determine the associated risk factors in both of these circumstances.

Studies continue to show that breast-feeding saves lives. It provides impressive nutritional, immunological, psycho-social and child-spacing benefits. Breast-feeding helps protect children from dying of diarrhoeal diseases, pneumonia and other infections. For example, artificial or inappropriate feeding is a major contributing factor in the 1.5 million annual infant deaths from diarrhoeal diseases. Moreover, breast-feeding can prolong the interval between births and thus make a further contribution to child survival, as well as enhancing maternal health.

It is therefore important that the baby's risk of HIV infection through breast-feeding be weighed against its risk of dying of other causes if it is denied breast-feeding. In each country, specific guidelines should be developed to facilitate the assessment of the circumstances of the individual woman.

Recommendations

- **In all populations, irrespective of HIV infection rates,** breast-feeding should continue to be protected, promoted and supported.
- **Where the primary causes of infant deaths are infectious diseases and malnutrition,** infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby's risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed.
- **In settings where infectious diseases are not the primary causes of death during infancy,** pregnant women known to be infected with HIV should be advised not to breast-feed but to persue a safe feeding alternative for their babies.
- When **a baby is to be artificially fed, the choice of substitute feeding method and product** should not be influenced by commercial pressure (...) If donor milk is to be used, it must first be pasteurized and, where possible, donors should be tested for HIV. When wetnursing is the chosen alternative, care should be taken to select a wet-nurse who is at low risk of HIV infection and, where possible, known to be HIV-negative. ❑

Excerpts from: "Weekly Epidemiological Record", World Health Organization, 12 June 1992.

Romania

A Family-type Alternative for Children with AIDS

Tolbert McCARROLL*

At the time of the down fall of Ceaucescu, more than half the European children with AIDS were Romanian. If the number of children infected by contaminated blood or syringes has greatly decreased, those of children born to HIV-positive mothers continues to increase. In order to avoid the children being placed in an institution, Casa Speranta offers a family-type alternative with which the local Romanian community is associated.

In 1989 Romanian pediatricians were threatened with imprisonment should they draw attention to the growing crisis of children with AIDS. The greatest number of infected children lived near the ancient seaport of Constanta on the Black Sea. In more than one of that district's institutions the first

* Monk of the Starcross Community in Sonoma County, California; author of "Morning Glory Babies : Children with AIDS and the Celebration of Life"; co-founder of Casa Speranta in Constanta, Romania.

children with AIDS were placed in dark rooms until they died. Their bodies were removed with the morning garbage.

The fact that over half of Europe's children with AIDS had been born in Romania was concealed until 1990, after the fall of the dictator Ceausescu. Since that time few children have been infected with contaminated blood supplies or syringes as in the past but the number of children born to HIV-positive mothers has increased at a distressing rate.

International relief efforts focused primarily on improving the conditions of poverty and neglect in the institutions where children with AIDS were warehoused. In January of 1991 Casa Speranta (House of Hope) was established in Constanta. It was unique in that it attempted to demonstrate an alternative to the institutions.

Children of Casa Speranta

American volunteers served as temporary foster mothers for children formed into stable families of five. There were modest apartments for six families at Casa Speranta. At that time the majority of the local medical establishment could not envision children with AIDS living in a home-like environment. Children were summarily taken from their natural families and institutionalized when diagnosed HIV-positive.

Because health officials did not understand the potential for children with AIDS to live satisfying lives little assistance was provided. One ranking official described infected children as a «waste of medicine who will all die like apples dropping from a tree.» The 30 children at Casa Speranta came from institutions where children did live only a few months. Our children would have been dead also had they stayed. They would have died not from AIDS but from starvation. In the institutions bottles were given and taken away on a schedule. In contrast, the foster mothers would often spend hours feeding an individual child until she/he learned how to eat.

It was over two years before the first of our children died at Casa Speranta. Dragos had come to us frail and timid. We were told he would certainly not live more than a few months. He learned to eat with great gusto, became fast friends with his new brothers and sisters, learned to ride a tricycle, to pore over all the storybooks, and to ask keen and insightful questions. It soon became apparent he was a very intelligent young boy. In fact, it was specifically because of him that we realized our children in Romania needed the challenge of school as well as the love of a stable family. Dragos inspired us to establish a Montessori school for our children.

Casa Speranta was founded by the Starcross Community which is not a child-care agency. We are a small autonomous community of lay-Catholics in spiritual solidarity with the Cistercian tradition. Our interest in Romania's children came from our experience in the United States where, in 1986, we became one of the first to provide in-home care for children with AIDS. In most situations we have adopted a child at the request of the natural mother. It is an open adoption in which we maintain a relationship with the birthmother.

Romanian women take over

Having helped pioneer a highly successful model of compassionate care in the United States we hoped to duplicate our experience in Romania. This has been only partially successful. We have been disappointed that Casa Speranta has not been duplicated. More successful has been the example Casa Speranta provides that the children can live normal lives. As a result of Casa Speranta families with infected children are no longer being advised to give up their children and put them in institutions. Two of the children from our own program have gone back to their families. A basic medical support system has recently been established for families in the area living with AIDS.

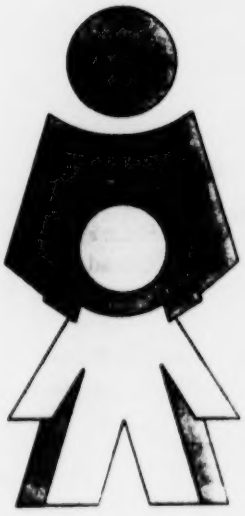
In 1992 we were able to train Romanian young women to be foster mothers replacing the American volunteers at Casa Speranta. Working under supervision, they have provided an increased stability in the lives of the children. The present foster mothers are proud of the fact that Romanian women, rather than foreigners, are now parenting Romania's previously discarded children.

We operate on a modest budget. Nonetheless, we have felt it necessary for the local Romanian authorities to accept some responsibility for the children and have gradually negotiated to where approximately 25% of the expense is now borne by the local authorities.

Casa Speranta has been well received by the people of Constanta. Ordinary Romanians emerging from a nightmare of political and cultural oppression seem to share with us the attitude that no child should be excluded from the human race for AIDS or any other reason. ❑

For information : Starcross Community, P.O. Box 14279, Santa Rosa, Ca. 95402, USA. Tel. (707)526 01 08; Fax (707)526 62 16.

France



Solidarity with Children Affected by AIDS (Sol. En. Si.)

A centre to welcome children and families affected by AIDS

The AIDS epidemic is not slowing down. In sociological terms, it has shifted. Affecting single people initially, it is now spreading increasingly in families, with several members of the same family being infected. It is not rare to find a family where the father, mother and one, or even two, of the children are affected. The emotional, affective and material shock is virtually unbearable. What future is in store? Who is to blame? What resources are available? What aid ?

- At the moment in France, 500 children have AIDS.
- Approximately 2000 children are HIV-positive, without symptoms.
- It is estimated that there are between 40 000 and 60 000 HIV-positive women in France.
- Around 1200 HIV-positive women become pregnant each year.
- 50% choose to have an abortion.
- 600 children are born HIV-positive each year; 20% will actually be HIV carriers.

Sol. En. Si. has set itself the task of organising ways of ensuring that parents and children affected by AIDS can stay together as long as possible in good living conditions, and to cope as best they can with the various problems caused by this illness.

- Technical problems: the search for a job, housing, childcare facilities (creche, nursery nurse, day nursery).
- Relationship problems, loneliness, distress, helplessness, anger.
- Problems in having the child (or children) looked after.
- Problems with neighbours or public services, problems in tolerating the attention and disapproval of «others».

Qualified staff and trained volunteer workers have created a centre for welcoming and meeting children and parents, open 6 days a week, where the following facilities are available: day nurseries, a forum for parents to meet, individual interviews, and job-hunting and house-hunting workshops. The staff visit the families at home, often in liaison with social workers, and propose welcome solutions to HIV-positive or sick parents in the event that they are indisposed temporarily or in the long term (search for foster families, urgent fostering in cases of unforeseen hospitalisation, care of children during the weekend or school holidays, full-time host families for children who are ill and live in institutions). ❑

For information : Sol. En. Si., 35 rue Duris, F-75020 Paris, France. Tel. (33-1) 43 49 63 63. Original in French.

A children's book

«Come sit by me», by Margaret Merrifield, 1991. Published by Women's Press, 517 rue College, bureau 233, Toronto, Ontario, Canada M6G 4A2.

A book of instructive stories dealing with HIV and AIDS for children from 4 to 8 years of age and those who care for them. Useful practical information completes the book which is very attractively illustrated.

Switzerland

AIDS and Children Platform

The AIDS and Children Platform is a network consisting of representatives of various medical, social and support bodies whose job is to assist children who are HIV-positive and/or whose parent or parents are HIV-positive. Its objective is to coordinate the various forms of aid which is available to families affected by AIDS depending on the physical and mental health of each of their members and/or because of a difficult social situation.

The AIDS and Children Platform also attempts to look for, inform and support families, persons and structures willing to host children affected by AIDS or to support them. It has received a mandate from the Department of Education and the Department of Public Welfare and Health of Geneva.

Who can call upon the AIDS and Children Platform ?

- families or persons directly affected;
- social welfare and health professionals;
- persons, families and structures wishing to foster a child from a family affected by AIDS;
- persons wishing to provide aid to such families.

One of the organisations represented by AIDS and Children Platform is the ESPER Association. This is a group of voluntary workers informed of the special needs of HIV-positive children and/or parents affected by AIDS. The Association provides practical assistance such as childcare facilities, support in the case of sick children, and temporary fostering of children. It is present at leisure centres and holiday camps, well-informed of the special needs of these children in a relaxed setting.❑

For information: Protection de la Jeunesse, Secteur Familles d'accueil, 8 rue Adrien-Lachenal, 1211 Geneva 3, Switzerland. Tel. (41-22)787 63 60.

Italy

Arché

Association for solidarity with drug abusers and those who have AIDS

Fr. Giuseppe BETTONI

Arché is an association which cares for people affected by HIV/AIDS. It was founded in 1991 by a priest in a parish in Milan, Italy, and a group of volunteers. The Association, the first of its kind in Lombardy, deals in particular with home assistance to children who are HIV-infected and also those who have AIDS. At present, there are about 40 volunteers who cooperate with Arché, all of them well trained through courses given by qualified experts (doctors, psychologists, pediatricians of Milan University and a pediatrics team from Padua University).

Furthermore, every volunteer periodically attends refresher courses and seminars organised by the Association itself. The meetings between volunteers and doctors, psychologists, and social workers are held frequently in order to discuss the cases they have been entrusted with. The volunteers' tasks are as follows:

- give assistance to families during transfer from home to

hospital and vice-versa,
- be close to the child during day-hospital therapy,
- give assistance during the stay in hospital of serious cases; the volunteers are both a presence for the child and they keep in contact with the doctors regarding the evolution of the illness and treatment to be given at home.

Quite frequently, the parents of these children are ill or do not live at home, so the presence of trained people can give them not only practical assistance, but relief and moral support.

In the case of particularly difficult situations within a child's family, Arché, in order to give real and constant assistance in accordance with State structure, tries to place the child with a reliable family, but avoids uprooting the child completely from his/her environment. Every morning the child is collected from home and taken to the family who takes care of him/her until the evening when he/she is taken back home.

In this way, the child does not suffer from the separation from his/her family, thus contributing to his/her psychological and physical well-being.

Arché also organises get-togethers and parties for the children: last year 35 children from various parts of Lombardy attended a Christmas party. Holidays are also organised with qualified staff in attendance to give the children the opportunity to live moments of serenity and creativity and for the volunteers to enrich their training and contribute to personal growth.❑

For further information: Fr. G. Bettoni, Director Arché, Via Cagliero 26, I - 20125 Milan, Italy. Original in Italian.

United States

A System of Care for Families and Children with AIDS

Bro. Robert ROBINSON*

As an increasing number of families, women and children become impacted by HIV disease we must develop and support services which meet the diverse needs of this population. The needs of these families require a system of care which includes not only medical assistance, but also assistance with counseling services, drug treatment, housing, legal services and child care. This care must be family-centered and link children and families with health and related services that are both community-based and comprehensive. How do we effectively develop this system of care and respond to this second wave of the HIV epidemic?

In Chicago, we have attempted to address this situation with the development of a unique and dynamic network - the Families & Children's AIDS Network (FCAN). The vision for FCAN began in 1985, when Mr. Shelton Key, Director of Social Work at Children's Memorial Hospital (CMH), saw the number of HIV-positive babies and young children at CMH rapidly increasing. He felt that it would be beneficial to form a group concerned about pediatric AIDS, and invited various professionals to meet to discuss the situation.

As the cases continued to rise and problems continued to be encountered, the group began to meet more regularly and incorporate around their shared concerns. The group widened its focus to include not only children but also these children's families. Following the completion of a needs assessment in the summer of 1988, FCAN was incorporated in November, 1988.

Today, the network is a coalition of more than 1500 organizations and individuals composed of: caregivers and other professionals in the field of AIDS; other constituents not formally allied with AIDS organizations; schools, businesses; HIV-affected and foster families; maternal and child health and welfare groups; church groups; individual workers in several fields whose employers as yet do not recognize HIV as their concern or for whatever reason have not developed agency capacity to address the issue; and, members of the community-at-large. This

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interdisciplinary, cross-societal group both informs AIDS dialogue along broad lines and offers the diverse membership an entrée into the struggle against AIDS in families and children.

FCAN has as its mission the development of a coordinated network of comprehensive services for HIV-affected families and children. FCAN approaches this mission on three separate but related levels: education of service providers and the public; advocacy on behalf of HIV-affected families and children: and, coordination and stimulation of services to fill gaps in care.

Education services

Through these services we seek to educate the general public, human service providers and caregivers on HIV-infection in children and families. Education forums are presented monthly on professional support and in-services, casework problem resolution and service coordination.

FCAN reaches a larger network, through its newsletter, the "Network News". This newsletter is filled with details of information on the dynamics of AIDS that are unique to families and children. It includes service resources and the input of caregivers, as well as national and local issues related to HIV among our population.

FCAN staff and volunteers give public talks on AIDS in the family, pediatric AIDS, and public policy in AIDS. These talks are given to groups such as day care centers, churches, schools, businesses and social groups - all organizations coming to grips with AIDS and how it affects or will affect them. FCAN also organizes and sponsors special forums, seminars and conferences.

Child Welfare League of America

Publications and Videos

The Child Welfare League of America (CWLA) and the Children's National Medical Center, home of Project CHAMP (Children's HIV/AIDS Model Project), have jointly produced *Hugs InVited: An Educational and Training Series*, which includes a trainer's guide with participant manual, a handbook for caregivers, the *Hugs InVited display poster*, and four 15-25 minute videos: *Caring for Infants and Toddlers with HIV Infection, Caring for School-Age Children with HIV Infection, Adolescents: At Risk for HIV Infection*, and *Living with Loss: Children and HIV*. A discussion guide accompanies each video.

CWLA has also published *Courage to Care: Responding to the Crisis of Children with AIDS*, edited by Gary Anderson and available in both hard and soft covers, and three specialized guides: *Serving Children with HIV Infection in Child Day Care; Serving HIV-Infected Children, Youths and their Families;* and *Meeting the Challenge of HIV Infection in Family Foster Care*. The video *With Loving Arms*, a portrayal of three foster families caring for HIV-affected children, also includes a discussion guide.

For information: Child Welfare League of America, 440 First Street NW, Suite 310, Washington, DC 20001-2085, USA.

Advocacy services

As the number of cases in women, families and children continue to rise dramatically, we are undertaking aggressive efforts to address barriers and limitations in services. FCAN's Family AIDS Advocacy Committee, a group of nearly 15 family AIDS service providers, works together to develop strategies which will dismantle these obstacles.

This Committee advocates at all levels for the needs of HIV-affected families and children. We organize initiatives such as letter and telephone campaigns and meet with appropriate officials to influence public policy and funding affecting our families. We provide endorsements and/or publicity on local initiatives as well as on national projects.

Last year, this Committee worked successfully with the Illinois State Legislature to expand guardianship options which will enable parents with AIDS to plan better for the placement of their children following their incapacitation and/or death.

Coordination/stimulation of services

Our third goal is to provide coordination/stimulation of service to fill gaps. Currently, limited money is available for services for women even though they are the fastest growing group of people with AIDS. We mentor programs moving into AIDS work such as a battered women's shelter which will be providing housing for women with AIDS. We train and educate day care center and foster care program staffs to help them prepare for serving HIV children. We also encourage linkages between organizations to coordinate care and foster cooperative ventures between organizations to provide better systemic care.

FCAN also serves as an incubator for the development of programs to address major gaps in service. For example, the 20 members of the FCAN Respite Care Task Force, worked for more than two years to design and implement a respite care program for families. This program provides center-based day care and in-home respite care, as well as family support services and resources. In projects like this FCAN identified needs, incubated and nurtured a program to fill the need, and then let it go. This program is administered by Chase House, an organization that has no previous experience in AIDS but extensive experience in child welfare.

Although coalitions are an effective means of advocacy needed to maximize resources, funders typically prefer to support direct services. AIDS funders are increasingly recognizing the need for collaboration, but the monies supporting it have lagged behind, with grants earmarked for prevention education and direct service. The comprehensive needs of HIV-affected families, women and children, coupled with the rate of the epidemic's growth among this population, however, demand the interagency cooperation and aggressive advocacy that FCAN provides.

FCAN's strategic plan establishes goals for staff and members to implement programs and services which will address major concerns in the family AIDS community. The overall objective of this plan is to maintain FCAN's proactive stance regarding families with AIDS.

We must remain at the forefront of this battle as the number of cases continues to rise in women, families and children.❑

Summer camp for families with HIV-positive children

"Having the chance to meet different people and sharing and finding out that we're not alone has been such a comfort to me and made me feel not so alone in the situation."

These are the words of a parent whose three-year old girl is HIV-positive who had a chance to spend a week with her family at Blueberry Cover summer stay camp in Maine sponsored by the Tamarand Foundation in New York City. Painter Jon Moscartelo of the Blueberry Cove Foundation approached Joe Mondello and Bruce Detrick of the Tamarand Foundation with the idea of offering a week-long summer stay at Blueberry Cove for families with HIV-positive children. For the Tamarand Foundation, whose mission is to bring nature and art to hospitals and homes for children with AIDS, the camp offered the ideal, a chance to bring the children to nature instead of the other way around. The basic tenet of the Tamarand Foundation (named for Joe's six-month old niece, who died of AIDS, as did her mother, who was infected through transfusion) is that life is nurtured by life. As Bruce says, "the spirit may be whole though the body is ill."

Thirteen families from Providence, Boston, New York and New Jersey participated in the summer camp. Some children came with HIV-infected mothers, other with foster mothers or aunts because their mothers had died of AIDS, and/or with older siblings, children free from the infection. Besides cooks and a nurse with a direct line to AIDS pediatricians, the staff included musicians, naturalists, storytellers, and, from Columbia Teachers' College, an artist and a dancer. The idea of the camp was to offer a little time out, a place to play, a safe haven where nature, art and music could provide a supportive and healing environment. In addition, the camp offered the parents and children an additional support network while giving them hope and surrounding them with caring. ❑

Excerpts from "Partings and other Beginnings" by Ruth Rudner. Copyright © by Ruth Rudner. Reprinted by permission of The Continuum Publishing Company, New York.

For information: The Tamarand Foundation, Inc., 202 Riverside Drive, 7D, New York, NY 10025, USA.

Talking to Children about HIV

Children born before 1984 who received treatment for their hemophilia could be at risk of infection with HIV. Other children in a family may also be concerned about HIV/AIDS. If their brother, father, uncle or grandfather has hemophilia, it is therefore often a good idea to talk to children about HIV.

Children may have heard about HIV/AIDS from other children, television or teachers at school. What they know may be full of myths and inaccuracies. They can therefore be frightened and alarmed by the condition. They may also sense that parents or guardians are worried about something. This might exaggerate their own fears. Some children may have guessed they have HIV themselves or that a family member does. Without accurate information and someone to talk to, they may be unduly worried.

When you start talking to children about HIV/AIDS, it is a good idea to find out exactly what they know about it beforehand. Talk to them in simple language and be prepared to answer any questions however personal and sensitive.

Being open about HIV within the family does, in general, have a positive effect. If one or two people in the family are in some way living with a secret or a lie, it can place a heavy burden on them and other family members. In most cases, being honest about HIV is a relief for all concerned.

Telling a boy with hemophilia he has HIV

If possible, parents or guardians should try to talk to a child with the virus about HIV well before he becomes sexually active. This could be at about the time he is learning to understand hemophilia. By talking to a child at this age he can grow up with an understanding of both conditions.

If a boy is told he has HIV when he is becoming sexually active he may then have the double difficulty of dealing with adolescence as well as HIV. If parents wait until their child becomes ill, this can also be a difficult time to discuss the cause of his health problem.

"While I was frightened about telling my child he seemed almost relieved as he had apparently wondered why we were avoiding his questions. It is certainly easier for us all now that we can talk about it."

As you may be making more

frequent trips to your hemophilia or treatment centre, you might want someone at the centre to talk to your son about HIV and what it could mean to him. Telling a child about HIV can be an ongoing process which may take many long conversations.

What schools need to know

HIV will not necessarily affect a boy's progress through school. Boys with hemophilia and HIV should be encouraged to pursue the career of their choice.

Discussing HIV with people at school is, like talking to employers, a personal choice. You are under no obligation to tell the boy's teachers. Although some argue that the head teacher or principal should know. That way the boy's progress can be monitored. If you do tell them, ask them only to discuss it with people you want to be told.

Another reason for telling the head teacher or principal is that if there are other infections in the school, then the principal can recommend that the boy with HIV stays at home. That way, the boy can avoid illnesses which could further damage his immune system.

If a child becomes unwell and needs to take frequent time off school, you may consider it necessary to talk to his teachers. That way, the school can, if necessary, rearrange the child's workload and make other arrangements. If a school is causing you problems around HIV, contact your National Hemophilia Organization for advice.

If another family member is sick with HIV related problems, it might be worth mentioning to a child's school that someone in his/her family is ill. That way, if the child is upset or disturbed, teachers will be able to understand. ❑

Extracts from "Hemophiila, HIV and AIDS - Choices for Living", World Federation of Hemophilia, World Health Organization, Price-Patterson Ltd, Montreal, 1990.

For information: World Hemophilia AIDS Center, 10 Congress Street, Suite 340, Pasadena, CA 91105-3023, USA.

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Philippines

Street Children, Children at Risk

Mgr. Francisco G. TANTOCO*

Recent news reports say that off-duty policemen in Rio are gunning down street children... as if they were vermin to be exterminated from the face of the earth.

In Manila, off-duty policemen, armed to the teeth, assist private real-estate developers in dismantling, bulldozing squatter shanties and forcibly ejecting the poor from their shelters to pave the way for the construction of glass towers, factories, condominiums, shopping malls or townhouses for the rich - without concern for the legal processes and requirements in the humane and peaceful relocation of the homeless poor. Not a few women and children are hurt and killed in this mad scramble for modernization, industrialization and profit.

Decry the oppression of the children

Bishop Michael Bunluen Mansap of Thailand, in a paper he delivered in Manila last July during an international conference on child labor sponsored by the Pontifical Council for the Family, painfully decried the oppression of the poor, especially the children, in the developing countries' pursuit towards industrialization, high profits, low labor costs and cheap pleasures. He says: «In this ruthless environment, to be young, and therefore weak and poor, is a crime punishable by exploitation; a crime against a new world order of profitable materialism and physical gratification. And the sentence for this crime ? Child labor and child prostitution...» He views child prostitution not merely as a form of child labor but the most debasing form of child labor... of child slavery.

In disasters, in wars, and in conditions of mass poverty, famine or plague, it is the children who are not only the most vulnerable but who actually suffer the most from the consequences of these unfortunate events. It is they who are most helpless and least able to defend themselves.

* Director of Caritas Manila, Philippines.

If we hold that the youth, the children, are the hope of the nation and of the world; are our most valuable (and vulnerable) assets; are our investments for the future; are our future - then now is the time to attend to their needs; to protect their rights and to create for them an environment conducive to their growth and development. This environment should be viewed not as a by-product of progress but rather as a means of progress.

During the past two decades, we in the Philippines, where more that 50% of our people live on or below the poverty line due to the inequitable possession, control and distribution of the income and wealth of the nation, have been struck by a series of disasters (both natural and man-made) causing greater suffering among our people - especially the children.

Of Manila's 2,5 million children below 15 years old, 1 875 million live on or below the poverty line. Of these, about 75 000 are street children, who have run away from home or have been abandoned. To survive, they work the streets for about 12 hours . . . begging, stealing, scrounging garbage bins for left-overs, selling newspapers, cigarettes, leis and, in a number of cases, their bodies. To deaden their pain, they take drugs (usually glue sniffing).

For street children, an added devastating risk

Today, these children are exposed to an added risk whose consequences are potentially more devastating than those they are presently exposed to. This risk is HIV/AIDS infection.

While statistics from 1984 to July 1993 tell us that only 397 have been diagnosed in the Philippines as HIV infected, including 100 full-blown AIDS cases (67 of whom have already died), health officials, however, believe that the actual number of HIV cases is hidden behind fear of exposure and ostracism, stigma and shame. Some say that the more realistic figure would be 50 times the recorded cases.

Studies of the HIV/AIDS situation in the Philippines indicate that 91% of reported HIV infections belong to the 15-44 age bracket; that the male/female infection ratio is 1 to 1; that the transmission rate is 45%; that the most common mode of transmission is through hetero-sexual encounters with infected tourists, tourist infected local prostitutes, or with Filipino overseas contract workers, on home leave, who may have been infected in their sexual encounters abroad.

From the above data, it would not be unreasonable to infer that the remaining 9% of HIV-infected persons are outside the 15-44 age bracket.

While we know of only one case of a child perinatally infected with and who has died of AIDS, we can safely assume that a number of children, under 15 year old, are infected with HIV due to a rather significant incidence of child (sexual) abuse and child prostitution in the country.

The risk of HIV infection for child domestics sexually abused by their employers or children incestuously abused by their elders would be low unless their abusers are HIV infected or that their abusers share them with others who are infected. Higher on the HIV risk scale are foreigner «kept» child prostitutes, about 300, mostly boys, in Pagsanghan, a town about 100 kilometers southeast of Manila. These «kept» children are normally not available to anyone but their patrons and their patrons' friends. Those that belong to the highest HIV risk category would be the 20,000 (out of the approximately 75,000) Manila street children who have already been driven into child prostitution. Because of the extremely difficult circumstances under which street children live as well as the «big» and «easy» money of foreign tourist pedophiles and ephebophiles, more and more of our street children are being driven into the flesh trade. Because of the frequency of their sexual encounters and the multiplicity of their partners, street children prostitutes are particularly vulnerable to HIV infections.

Information - Education - Communication

To help stem the further spread of HIV/AIDS which can further enervate our already prostrate people, Caritas Manila has taken a few modest steps, some of which are:

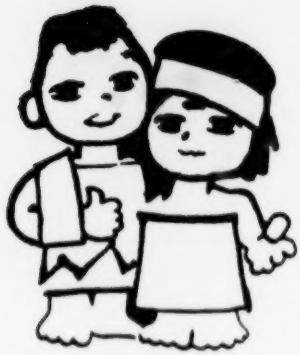
- The development of an IEC (Information, Education and Communication) program for HIV/AIDS prevention. The information dimension of the program aims at dispelling misconceptions about the disease by providing the public with factual data on what HIV/AIDS is, how it is transmitted and how it impacts on the individual, his/her family and society. The education component of the program is in the reorientation of values: an invitation to rediscover and reaffirm the meaning, beauty, and mystery of love, sex and life. The communication component has, initially, been limited to the production and distribution of posters and flyers, press releases to print media as well as organizing and conducting seminars for various groups on HIV/AIDS. The use of radio and television is being planned for the near future in order to reach the masses.

• The decision to focus our IEC program on those who have direct influence on and are in direct contact with people: the clergy, religious and civic associations, educators, social and health workers. We have, to some extent, reached out to some of those who are at risk: students in the secondary and tertiary levels, inmates in municipal and national penitentiaries, those in drug rehabilitation centers, organized families in the slums as well as the street children whom we have reached through our drop-in centers, «Morning Glory», «Bukid Kabataan», and «Sagip Moral» programs.

• Our collaboration with advocacy groups that monitor, expose and denounce all types of human rights violation, oppression and exploitation.

• Our networking with other children-oriented agencies (both governmental and non-governmental) in getting as many of our street children off the streets as our resources permit by providing them temporary shelter or referring them to foster homes, by sending them back to school or training them to acquire marketable skills.

Caritas Manila's reaching out to street children is not so much to help them specifically avoid HIV/AIDS and other STD infections as to help them rebuild their lives - already broken and brutalized by the ruthless environment of the streets. Unless we make them whole again, we ourselves will never be whole. ❑



Brazil

A Clinic for Street Kids

Dr. Irene K. Bruinsma ADAMS *

Medical attention, like all attention, should be educational and empowering, not purely assistential. Through the intimate contact between nurse and doctor with the street youth, a message of commitment, respect, and self value is transmitted. This is the philosophy of Clínica Ammor, the Street Kids Clinic of Belo Horizonte.

As a result, over 600 children have come for an average of four visits in the first three years. Their ages range from newborns to over twenty, 80% are between 12 and 18, 25% are female. Since May, 1991, over 50 youths have had complete check-ups, half have returned for their second visits, and continued regular returns are actively being promoted. Eight HIV-positive youth have been followed until now, and indications are that this need will continue.

Successful AIDS prevention must be linked to projects concerned with the reality and reasons for the marginalization of street children and promote changes at this level.

Belo Horizonte is the third largest city in Brazil with a population of 3.5 million. The children who live, love, sleep and eat on its streets are rejects or runaways from family poverty and violence in shanty towns or the rural interior of the state of Minas Gerais. As loners or organized in gangs they rely on scavenging, odd jobs, petty theft and prostitution for survival in a setting of continuous threat from police and rival gangs. Mutual distrust marks their relationships with outsiders. Criminalized, with no adult guidance, they will first satisfy their survival and food needs and then seek pleasure, usually in the form of drugs and sex. Worries about health are limited to emergencies, e.g., knife or gunshot wounds, traffic accidents.

Risk behaviour

Physicians at the Federal University of Minas Gerais became

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Street Kids and AIDS

An interview with Dr. Lair Guerra de Macedo Rodrigues, manager of the Brazil AIDS programmes, one of the world's largest AIDS programmes.

Brazil has a large population of street children. Are they at great risk of HIV infection?

The children living on the streets without any family structure are one of the most crucial problems facing Brazil. They are at great risk for three reasons. Firstly, many of them sell their bodies as a means of survival. Secondly, frequent drug use. Thirdly, their high prevalence of sexually transmitted diseases. They have all the risk factors you can think of: sex, drugs, STDs...

Are there any figures on HIV prevalence among street kids?

We have done some local studies which show a prevalence of 8.5% among teenagers between 15 and 19.

Are street kids very hard to reach with AIDS education?

Yes. Each state has an association to work with the street kids and now there is a federal organization. We are trying to collaborate on the implementation of good information programmes on AIDS and STDs. But I don't believe that a good information and education project alone will change the situation. Brazil has to address the problem in a more aggressive way to eradicate the roots of the problem. Approximately 36 million children are in need of support from Brazilian society.

From: Global AIDS News - The Newsletter of the World Health Organization Global Programme on AIDS, 1993 - No.3.

interested in this population as possibly at risk for AIDS and began a study of risk behaviour to develop a prevention strategy. In 1989, they financed the Street Kids Clinic of Belo Horizonte, as a joint venture with the Archdiocese Street Youth Ministry (Pastoral do Menor). Set up to study risk behaviour for HIV, it soon discovered a far greater need for medical care and education of which HIV is only a small part.

Clínica Ammor

Exclusively attending street youth, the Clinic is in the same church basement as the open house Day Center (Casa de Apoio aos Meninos de Rua) of the Pastoral do Menor. Here a doctor and a nurse offer drop-in care to street youth spending the day at the Day Center, self referred, or referred from other organizations with which it is affiliated. Complete check-ups, including HIV testing, are encouraged as part of an ongoing programme to develop body and health awareness. Medication and laboratory examinations are provided, but limited by the financial situation. Unique among health professionals of this city, both the physician and nurse are active outreach workers.

Children are referred to various specialized medical facilities in the city, as part of a continual process of empowerment of the children while educating other health care professionals to their reality.

Prevention of sexually transmitted diseases, especially HIV, occurs at the clinic, on the streets, and elsewhere. It includes sex and drug education of the children themselves and those who work with them. Early detection of HIV infection is incorporated in the regular medical and laboratory check-ups. Follow-up of HIV

infected children, in cooperation with street educators chosen by the youth himself, involves respect for his confidentiality, regular clinic visits, appropriate referral, and a concerted effort to find him an alternative to street life.

Special attention for street girls and their babies includes participation in a project started in 1989 by the National Street Kids Movement and the Archdiocese. Currently making tea towels to sell, the girls have their separate time with project educators and psychologists at the Day Center, jointly exploring the peculiarities of being female and on the street. Medical emphasis is on antenatal care, post partum care, family planning and well-baby care.

Since March, 1991, the Clinic has participated in what is now the Integrated Plan for Attention to Street Youth in Belo Horizonte. This group now comprises 17 governmental and non-governmental organizations which work with street youth in this city.

Ever more numerous needs

In order to improve and expand the services offered, the Clinic would like a social worker to help the children define and pursue their needs realistically, to visit the families, and to expand the clinic's referral network. A part-time pediatrician is needed to care for the many babies of street girls as part of their education for motherhood. A part-time gynaecologist-obstetrician is needed for those girls who refuse to go elsewhere for antenatal care and other gynaecological complaints. Funding is needed to continue and expand the range of laboratory examinations, especially in the case of detection and follow-up of seropositive children.

Helping them to discover their own worth

The Clínica Ammor is not an "AIDS Clinic". It is a Street Kids Clinic where AIDS is only one of the problems we attend. Its goal is to use medical and nursing care as an instrument to help our clients to discover their own worth and achieve their citizenship. Working with them, working with the community from which they have been excluded, and specifically concentrating on health care providers who play an important role in excluding street kids from appropriate health care, they can develop a new project for life as members of society. In this new context of a life which has a purpose, motivation to avoid AIDS, traffic accidents, and other preventable threats to their health will all follow. Those who perceive that they have been at risk for HIV infection will come for early detection and follow-up, and their colleagues will respect rather than reject them.

Having worked with AIDS and with street kids, prostitutes, and street people for over seven years, I have come to the conclusion that AIDS prevention among marginalized populations which focuses on condoms and facts about AIDS will not succeed. Successful AIDS prevention, early detection and accompaniment of infected persons must be conducted within the context of projects which are concerned first with the reality and reasons for their marginalization and which promote changes at this level. ❑

For information : Clínica Ammor, Atendimento Médico aos Meninos de Rua, Rua Adalberto Ferraz 31, Lagoinha Centro, Belo Horizonte, M.G., Brazil 31.210 - Tel. (55-31)444-3877; Fax: (55-31) 442-9182.

Research on AIDS: Knowledge, Attitudes and Practices among Street Youth

Working with local NGOs in the Philippines, Thailand, Colombia and Kenya, Childhope (with funding from UNICEF) recently carried out a qualitative research project to gather information from street youth regarding their knowledge, attitudes and practices related to sexuality, the prevention of HIV/AIDS and other sexually transmitted diseases, and related health issues. The youth in each site also participated in various AIDS prevention and sex education activities and commented on each.

Virtually all the youth in all four sites reported being sexually active from an early age and having a relatively high number of partners. For youth in all sites, sex represented a combination of pleasure or recreation, a source of income or shelter, and a source of power (in the case of gang rape). Youth in the Philippines reported survival sex (or prostitution) with foreigners and locals, including homosexual prostitution and anal sex. For girls in Kenya, even when they were not involved in trading sex for money - which was the main occupation of most - sex usually was exchanged for food or shelter or some favor. Males in Kenya, in addition to reporting prostitution with foreigners and locals (men and women), reported cases of forcing girls to have sex with them. At times they said this happened when they were under the influence of drugs. Similarly, in Bogota, males talked about forc-ing girls to have sex with them, as well as cases of gang rape of female members of the gang for punishment or initiation into the gang.

Males in Bogota reported that they frequented sex workers and a few had exchanged sex with men and women for shelter and food. Females in Bogota, while less willing to discuss the issue, reported that "their friends" were sometimes involved in survival sex, which they regarded as necessary for survival and to take care of their children. Staff in Bogota said that nearly all of the girls were previously involved in survival sex on the streets.

Sexual abuse, in addition to sexual exploitation through prostitution, was also common in Kenya and the Philippines. Many females in Kenya reported that their first sexual experience was the result of sexual abuse. A number of youth in Manila reported being sexually abused in a shelter.

Awareness/practices regarding STDs and AIDS

In all four sites, youth had a relatively high awareness about AIDS and STDs, although they had much erroneous information, particularly regarding modes of transmition and treatment of STDs

as well as symptoms. Youth in Bogota, for example, mentioned that one can find out if a partner has an STD by putting lemon juice on the genitals. Youth in Bogota also reported a number of cases of STDs. Similarly, in Nairobi, nearly all of the youth reported having had a STD at least once. (Among the 21 girls who participated in the discussion, seven had a STD at the time).

Nearly all the youth had a high awareness about AIDS and the modes of HIV transmission. In the Philippines and Colombia, however, this awareness did not result in personal fear or a belief that AIDS was something that could effect them. In Nairobi, on the other hand - perhaps because of multiple exposure to STDs - the youth perceived themselves as being at high-risk for HIV/AIDS and wanted assistance in prevention. Similarly, in Bangkok, perhaps due to publicity about AIDS, youth said they were personally concerned about the disease (which they attributed primarily to foreigners), and some had even requested HIV-testing.

In sum, the project reinforced the fact that street youth are at risk of HIV/AIDS due to their nearly universal involvement in prostitution or survival sex. (...) The frequency of sexual relations within the group of street youth also implies that one HIV-positive street youth could pass the disease to a large proportion of street youth. The Undugu Society conducted HIV-testing with 20 of the 21 girls involved (prompted by the detection of multiple STDs and other health indications) and found that four were HIV-positive. Two of the girls have returned to live with their families, while Undugu is providing shelter, support and counselling to the other two.

While youth in all four sites had a high awareness about AIDS,(...) there was a gap between their knowledge and realization of risk and the ability to translate knowledge into lifestyle changes.

In the case of youth living on the street and involved in survival sex, the overwhelming conclusion that emerges is that it is extremely difficult to discuss AIDS prevention without simultaneously addressing the underlying issues that place youth at risk. Since sex for street youth represents recreation, income and/or power, promoting healthier lifestyles and safer sexual behavior requires tackling these underlying issues.❑

Gary Barker, Excerpts from: "Esperanza" - Childhope-USA, Vol.5, Winter/Spring 1993.

For information: Childhope, 332 East 38th Street, 6th Floor, New York, NY 10016/ USA - Tel. (1-212) 983-1422.

Thailand

Sexually Exploited Children

Receivers and Transmitters of HIV

Ron O'GRADY

The AIDS epidemic is beginning to explode in Thailand and the signs are ominous that the Philippines and other Asian countries will soon follow. It has a specially damaging effect on the young. In fact, those who are looking for a reason to explain the sudden burst in the number of child prostitutes can find one possible explanation in the fear of AIDS.

Customers at brothels are very selective. (...) Brothel workers claim that their customers are particularly anxious to have a prostitute who "looks healthy". Since young children usually convey a stronger sense of being healthy than older jaded prostitutes, the demand for their services is increasing at all brothels. Many massage parlours in Thailand now have a separate room at the back where selected customers can be taken to view young girls, some as young as ten and eleven years, whose health is guaranteed and whose price is accordingly higher.(...)

The market for such girls is relatively new and seems to be related to the customer's belief that the young child is less likely to have AIDS. According to one local social worker, customers who wear a condom when they are with an older prostitute do not feel the same compulsion to wear one with young children.

Special vulnerability of children

But the tragic reality is that sex between a young child and an adult is more likely to transmit the AIDS virus than sex between two adults. The reason is that the blood tissues lining the male child anus and rectum and the young girl's vagina are thin and easy to rupture and this gives a direct passage for the HIV virus to the blood stream.

Medical examinations point to the fact that the sexual act of an adult upon the immature body of a child almost always results in some tearing of the tissue. The possibility of sexually transmitted diseases developing from the sexual encounter is therefore greater with a child, rather than less. The girl child being prostituted by several men a day ends with internal injuries such as bleeding and abrasions which never have a chance to heal. Since young girl prostitutes already have a high incidence of sexually transmitted diseases there will be many open sores through which the AIDS virus can easily pass.

If this message could be conveyed to paedophiles and others who want to have a sexual relationship with children it may contribute to a small reduction in the spread of the virus. This means educating tourists on the dangers of sexual relations with children since those on holiday are often very casual about their sexual relations.(...)

The prostitution of children, far from defusing the AIDS time bomb, will actually force the fuse to burn faster. ❑

Excerpts: Ron O'Grady, "The Child and the Tourist", ECPAT, Bangkok, 1992.
For information: ECPAT, PO Box 178, Klong-chan, Bangkok 10240, Thailand. Tel./Fax: (66-2)519 27 94.

Thailand

The Centre for Protection of Children's Rights

The Centre for Protection of Children's Rights (in Thailand) offers HIV tests (and counselling and follow up support) to the children and young women they help rescue from brothels. The results of those who have taken the test show a disturbingly high rate of infection. In 1991 a total of 185 tests were carried out, with the following results:

Age	Number Tested	HIV-Positive Number	%
< 17	85	26	30,6
17, 18	49	11	22,4
> 18	51	10	19,6

Thus, nearly one third of girls under 17, were found to be HIV-positive and the results are also consistent with the proposition that younger girls are more at risk. In more recent rescues it has not been uncommon for CPCR to find over 80% of girls rescued from hostels to be HIV-positive.

Other information from prevalence surveys also confirms a high rate of infection among sex workers. It has also been found that the rate of infection is higher in lower class, cheaper establishments - just the places where children are more likely to be found. One study in Chiangmai found that in brothels charging less than 50 baht per customer (approximately $1.40), 72.5% of the prostitutes were HIV-positive. In brothels charging 50-100 baht the rate of infection was 31% and in more expensive brothels, charging over 100 baht per customer, the rate was 17%.

Another disturbing feature is that there is suspicion that HIV-positive girls and young women from Burma, who have been found in brothels and repatriated from Thailand as illegal immigrants, (many of whom may be children, duped or kidnapped into prostitution) are being killed on their return. Although widespread, these suspicions have not been confirmed (ECPAT Bulletin No.13, 1993).

There is little information about the transmission of HIV infection to international tourists, but one study for the Federal German Ministry of Health estimated that around 10% (200-300) of new infections in Germany each year are contracted by sex tourists. ❑

Excerpt from: "Wish you weren't here - The Sexual Exploitation of Children and the Connection with Tourism and International Travel", Kevin Ireland, Save The Children, Overseas Department, Working Paper No.7, September 1993.

For information, Save the Children, Mary Datchelor House, 17 Grove Lane, London SE5 8RD, United Kingdom.

CPCR : 185/16 Soi Wat Deedwad (Charunsanitwong 12 Rd), Bangkokyai, 10600, Bangkok, Thailand. Tel. (662) 412 11 96; Fax (662) 412 98 33.

Nepal

A Cultural Prostitution

Rev. Margaret R. REINFELD*

Poverty, isolation and low social status of women all contribute to a significant incidence of girl trafficking in Nepal, most of whom are sold to brokers who send them on to India. As many as 200,000 Nepali women are now believed to be working in the brothels of Indian cities, most of whom were sold by their families when they were about eleven years old.[1] Because Nepali women are considered by Indian men to be particularly beautiful and exotic, the brothel owners are able to demand a higher price for their sexual services, particularly for those very young girls who are often presented to customers as virgins who are therefore perceived to be free of HIV and other sexually transmitted diseases. Not surprisingly, however, many of the brothel workers are actually infected with HIV: upwards of fifty percent of the women in a recent survey of Bombay brothels are said to be HIV-infected.[2]

The Bhadi of Nepal

In addition to conventional girl-trafficking, caste prostitution is also prevalent in Nepal. Among some distinct tribal groups, sex work is the traditional economic activity of the community. The Bhadi of Nepal are an example. Bhadi women train their daughters as sex workers, and when the child reaches the age of menarche, she is initiated in sex work, often with great ceremony. The money earned by the daughters supports the whole community. There is no social isolation associated with sex work among the Bhadi, so when the woman has grown old enough to retire from sex work, she is reabsorbed into the community. Few Bhadi women marry, largely because the families of men outside their caste object to alliances with former sex workers. Also, in a strategy to protect the community's livelihood, by tradition Bhadi men can marry Bhadi women only if the

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proposed bride comes from a family of at least three daughters. So rather than marrying, most Bhadi women have children through relationships with clients, and then raise them as single parents. The daughters are then, like their mothers, enculturated into the tradition of sex work. A recent study of Bhadi sex workers revealed that seventy percent suffered from sexually transmitted diseases.[3] While HIV has not yet made significant inroads into this community, the likelihood that it will in the near future is high, and the resulting human and cultural costs within the Bhadi community will be staggering.

The likelihood that the HIV epidemic will become established among these young women is very high: HIV is already prevalent among the sex workers in Indian brothels, so women returning to Nepal from India are at high risk of infection. Male seasonal workers returning to Nepal are also likely to be at high risk of HIV because of the frequency with which they patronize the brothels of India. Since these men are also likely to visit sex workers in Nepal, the potential for introducing HIV to a broader range of communities in Nepal is likewise high.

Conventional prevention programs have focused on teaching sex workers to use condoms with clients, and on helping them develop the negotiation skills necessary to do that. Yet for children who have been sold to brothels, the notion that they possess the power to change even the smallest aspect of their lives is ludicrous. They simply do not have the power to negotiate effectively with clients, and would in most cases expose themselves to the risk of violence if they tried. Even those children who grow up in caste communities where sex work is traditional cannot be expected to negotiate on their own behalf: the economic reality of the sexual marketplace is the controlling factor in their lives. As long as children command higher prices if they are believed to be sexually inexperienced and therefore free of disease, brothel owners will not lower their income by requiring condom use.

The ultimate prevention strategy for sexually exploited children is, of course, to end trafficking in girls. But control efforts have proven ineffective for many years, and it is unrealistic to expect that trafficking will, because of the potential of a large HIV epidemic, take priority for scarce resources over the myriad survival needs of a country where safe drinking water is a remote dream to much of the population. At best, ending child trafficking will take many years to accomplish. Unfortunately, the AIDS epidemic will not be held in abeyance while that work is completed.

A comprehensive, culturally specific approach to HIV prevention is the only alternative likely to avert catastrophic growth in the epidemic. In addition to educating clients of sex workers and brothel owners about condom use, efforts to support the young women are critical. For example promoting the establishment of community-based residential facilities for daughters of caste prostitutes will help to remove these young women from the day-to-day culture of sex work, and give them the opportunity to attend school and at least to postpone their entry into sex work. At the same time, advocates for the protection of children can continue to address the low status of women in Nepal and India. Until women are recognized as autonomous individuals who can make decisions that serve their own welfare, the culture of prostitution will continue to flourish and to victimize yet another generation of daughters.

Notes

[1] It must be noted that parents are not always aware that they are "selling" their daughters to brokers for Indian brothels. It is not uncommon for Nepali parents to be paid their children's wages for a period of time during which the child is said to be serving as an apprentice to a craft. Many parents believe they are sending their daughters to jobs in carpet factories in the cities, jobs which in their eyes will allow them to support themselves. They understand the payment they receive as an advance on their child's wages. Many of the young girls are then re-sold by brokers not to the factories but to Indian brothel operators, who may in turn sell them again to other brothels for a variety of reasons. Kidnapping of young girls in the countryside and then selling them to brokers is also not uncommon. While Nepali law prohibits such practices, both custom and the practical inability to police such activity in isolated rural areas, means that enforcement of the law is low.

[2] Nepal Field Office, Save the Children US, Proposal for Technical Assistance and Monitoring Project to Strengthen Local Non-Governmental Organizations, February, 1993.

[3] Pushpa Bhatta, "A Unique Community of Family-Oriented Sex Workers in Nepal Uninfected by HIV-1", paper presented at the Second International Congress on AIDS in Asia and the Pacific, New Delhi, November 10-12, 1992.

Uganda

Assistance Programme for AIDS Orphans

Sr. Ursula SHARPE*

The Mobile Programme commenced in 1987 and from small beginnings has grown into a substantial programme trying to respond to the needs of the AIDS affected community, as they have arisen. The Mobile Programme has three components : The Home Care Programme, the Orphan's Programme and the Education Programme. It was implemented at the Kitovu Hospital by the sisters "Medical Missionaries of Mary" and their collaborators. The Programme works in 15 Catholic Parishes in Masaka Diocese in Rikai and Masaka Districts. The target population are those clinically diagnosed as having AIDS, the «Worried Well» who wish to know their HIV Status, the orphans, where one or both parents have died, AIDS-affected widows and guardians, families affected by the AIDS epidemic, specific targets groups for AIDS Education.

On the waiting list, 2000 children in need of urgent assistance

The Orphan's Programme has precise objectives :

- To provide school fees, uniforms and scholastic materials to needy AIDS-affected orphans.

- To raise awareness among the orphans regarding the spread of AIDS and the importance of their sexual behaviour change.

- To facilitate peer counselling among the orphans and to provide individual counselling for those who need it.

- To stimulate their creativity through drama, song and art, and to provide recreational facilities - Scouting/Guiding, footballs, netballs, etc...

- To promote spiritual growth of the orphans in their respective denominations.

- To up-grade the teaching standard in the schools where we have orphans.

Although there are NGO's working in the area caring for orphans, we cover less than one third of these children who need assistance.

There is no family in the area who does not have orphans from relatives who have died from AIDS. As a consequence, even the children who are not orphaned feel the financial pressure of having extra mouths to feed and bodies to cloth in their families. In such a situation many stresses are encountered by the orphans - food shortages, lack of proper adult guidance, child abuse, etc... The programme is trying to assist them to cope with these situations and others in their respective homes/communities.

The children on our immediate waiting list number 2,000. These are children whose parents have used our Home Care Service, we try to re-assure the dying parent that we will take care of their children. Dying parents are always more concerned about what will happen to their children, than what will happen to themselves when they die. Who will care for them (their children)? Who will guide them ? Who will give them a future ?

«Drop-outs»

87 children left the programme during the year, 75 from primary and 12 from secondary schools. All of

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these were investigated by the programme staff.

Reasons for dropping-out :

- Death of a remaining parent/ guardian and the children are taken elsewhere to another relative.
- Death of orphan - some died from meningitis, rabies, tetanus, malaria, and accidents.
- Two orphans got pregnant.
- Circumstances at home forced them to drop-out to cook, work in the fields and care for sick parent(s) or elderly guardians and smaller children.
- When all the adults died, the eldest child had to stay at home to care for the younger ones.
- Getting «married» - girls going to live with an older boy or man.
- Lack of interest in school.
- Starting to work... «do business».

Social and behaviour change programme

As a result of the orphans meeting together in groups regularly and being facilitated by a member of staff, a high level of trust within the individual groups has been realised. Because of this, some research was able to be done by our progamme staff.

- To what extent are orphans engaged in sexual activities and why ?
- Is it possible to influence sexual behaviour in orphans ?

Results :

By the age of 12 years, 30% of girls are sexually active rising to 85% by the age of 18 years. For boys, by age of 14 years 10% are active, rising to 70% by the age of 18 years. First sexual experiences are characterised by pain, guilt and both bad and good feelings which influence later sexual experiences. Reasons for becoming sexually active include : economic need, peer pressure, discovery, rape (by strangers, relatives, teachers) and lack of parental supervision.

Lessons learnt: since major reasons for sexual activity are economic need, peer pressure and coercion, help with income-generating activities, peer group sensitisation and education stressing sexual behaviour change and negotiating skills are needed.

Main problem : the lack of personnel

Besides the ever-increasing number of orphans, our main problem in this part of the programme, is lack of personnel. Each of the two districts has an Orphan's Co-ordinator and there is an overall Manager of the Programme. However they are out visiting the

Parish/community leader's AIDS course

This programme, commenced in June 1992, has the following objectives :

- To educate the local community leaders.
- To train these leaders in communication and teaching techniques and in sexual behaviour change.
- To help AIDS-patients die with dignity through training in patient care and basic counselling skills.
- To promote good child care in the family, especially in relation to the many problems of AIDS-orphans.

There are 38 Catholic parishes in Masaka Diocese which comprises Rakai, Masaka and Kalangala districts. The population is 1,2 million people.

Each parish priest and his parish council were informed of the course by the diocesan laity commissioner. Parishes selected two people from each sub parish to a maximum of 35-40 people. They were to be leaders and actively interested in the AIDS problem. All denominations were to be included among the participants.

Between19-60 participants participated in 28 parishes. The ideal number for a group is 35 people.

Despite our request for one third female participants the majority were men - 51% men; 21% female; 12% youth.

The duration of the course is initially 3 days residential. After 3 months they return for another 3 residential days. It is residential as much group work and discussion goes on in the evenings. We return for one day «follow-ups» every three months. At the end of Part I, they elect a coordinator. Each month they meet themselves to discuss their problems and achievements and to review their plans.

Accommodation was provided for the participants by the parish, in most cases, in schools or parish house. Food was contributed by the Programme and the community contributed in all cases.

Some groups of participants have also started income-generating projects with they themselves contributing small amounts of money to set them up and the parish giving land. The proceeds go to help the orphans in their area.

508 certificates have been presented to the participants who have completed the 3 seminars/ courses successfully. They also receive a hoe to help them in their efforts of self-reliance and as a small token of appreciation !

Course Content

Part I

- **HIV Infection - AIDS :** Definition - Signs/symptoms - HIV Testing - Control - Prevention.
- **Community-based Care of AIDS patients :** Physical and Nutritional Care - Psychological Care - Spiritual Care - Family Care.
- **Communication/Teaching Skills : How to communicate** including the use of Posters and Flip Charts. Input and discussion on Education for Behaviour Change.

Part II

- **Review of Part I** - Reports from their 3 months work period.
- **Counselling :** Basic Counselling/Helping Skills
- **Child Care :** Psychological Development of a Child - Psycho-social impact of AIDS on children - Child care associated with the effects of separation and/or death of parent/s.

Evaluation / Future Planning.

For information : Sr. Ursule Sharpe, Kitovu Hospital, Masaka, Uganda.

orphans, in their homes and schools: running seminars for the orphans and their guardians : trying to keep the records and the paying of school fees up to date. They are also involved in giving input during the courses for the parish/community leaders and to the community workers during their training workshops on the development and care of the child. The work is far too much for three people and they are all also involved in the co-ordinating meetings at district level. Two extra teachers for this programme were recruited in early 1993.

Income-generating projects at some schools were supported. We cannot force schools to have such projects, it depends on the vision and enthusiasm of the headmaster and teachers. If run properly, they can be a source of food and income for teachers and students.

Due to the severe drought and resultant famine in Rakai and Masaka districts, several school closed as children were not getting food at home and were unable to study due to hunger. Maize and beans were supplied to some of these schools where we have orphans and classes resumed.

Footballs and netballs were supplied to schools where we have orphans.

Guardians' seminars

We continue to meet the guardians regularly. During these meetings the following have been discussed :

- Need for orphans to attend school regularly. Guardians may keep the children at home if they need them for chores e.g., digging, fetching water or firewood. These could be done before or after school hours.

- Importance of income-generating activities to minimise food and money shortages.

- Co-operation beetween the guardians and the school administration and some of these guardians becoming involved in the Parent Teacher Associations (PTA). As many of the guardians have little or no formal education themselves, they are often over-awed or intimidated by the school system and by the teachers. The result is that they do not get involved in their orphan's education, to the detriment of the child.

- Information on sex education and on the sexual behaviour change process. Many elderly guardians find it difficult to discuss such subjects with their grandchildren and may be somewhat ignorant themselves about the spread of AIDS.

Income-generating activities

This aspect of the programme has for objective to find solutions to address and alleviate the economic consquences of AIDS and to facilitate and support group solidarity among AIDS - affected guardians and orphans.

Different types of projects have been set up, such as cultivation of seasonal crops, piggery, horticulture, poultry, brick-making, trading.

This area of Uganda has two rainy seasons per year. However, the

ICCB - Abidjan

A community-based project for AIDS orphans

In the Côte d'Ivoire, it is expected that the number of AIDS orphans will reach 400.000 in 1994.

After having carried out an extensive study, the ICCB is now preparing a community-based project which will be operational in 1994.

It is expected that AIDS orphans will be permanently placed with the extended family or other responsible adults within six months of losing their parents. Every effort will be made to ensure that the family lives within proximity of health and educational facilities. In keeping with African cultural traditions, it is hoped that the child will be successfully integrated into his/her new family and community.

The families will be trained and equipped with appropriate means to start income-generating projects that will continue to sustain the children's development, particularly their educational needs. This is particularly important for the female child since her education is viewed as a lower priority than that of a male child.

In addition, the project will attempt to educate the public about the HIV virus and AIDS and the situation of these AIDS orphans. The project will exercise prevention efforts through education, counselling and peer support.

For information : ICCB, 01 B.P.1721, Abidjan 01, Côte d'Ivoire.
Tel. (225)22 87 07; Fax (225)32 45 89.

rains of March - May were poor and some areas received only a few showers. The rains due in September were 4-6 weeks late and again were insufficient. Crops burnt and died in the fields. In 1991, there was also a drought but not as severe as this year's.

Many familes have suffered, especially the most vulnerable-families with AIDS-patients: orphans living with aged guardians and orphans living on their own. During the second rains, the areas which did receive sufficient rain, where we have projects, had a good harvest of beans, maize, potatoes, groundnuts and sorghum plus vegetables.

Each group project comprises 2-5 acres of land which is donated by someone in the community. Our contribution is the ploughing of the land. The guardians usually provide the seeds and do the planting, weeding and harvesting. Each project is worked and managed by the guardians and orphans with the community workers from that area assisting. Each project elects their own committee and the harvest is shared or sold.

If the weather is as it should be, these group projects have great potential. If the weather is not, it is very disheartening. However, despite the elements of nature, these projects have begot a spirit of solidarity among the guardians. They spend much time discussing among themselves and no longer feel alone with their many problems.

Hoes have been given to the gardians and orphans working in the projects, but not until they have proved that they are interested and working.

Several families have little or no land due to :

- The father having had to sell it to get money during his long illness.
- It was taken by the father's family when he died - permissable by local customs.
- Refugees/displaced status of the family. Many families here have come from Rwanda, Tanzania or more densely populated parts of Western Uganda. They work as daily labourers and cannot afford to buy a piece for themselves, to ensure that the children will have it for their future.

Some families do have land but due to the parent being ill or an elderly guardian with young orphans, they are physically unable to cultivate it. We pay for the first and second ploughing and seeds if necessary. Usually they can then manage to continue.

Smaller groups and individuals have received help in setting-up pork, poultry and fruit businesses. Those having suitable soil and expertise to make bricks have excellent and profitable projects. One brick-making group of orphans and community worker's made 20 000 bricks this year.

Besides the weather, the main problem with this programme is lack of trained management and agricultural/veterinary expertise. To solve this problem, suitable people may be recruited.❑

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Rwanda

AIDS Orphans

Problems and Solutions

Fr. Michel DESCOMBES*

Like most other countries of Central and Eastern Africa, Rwanda has been cruelly stricken by the AIDS epidemic. In this small state of 7.5 million inhabitants, frequently referred to as a rural country, but with one of the highest population densities (280 inhabitants/km) in the world, AIDS has progressed at an alarming speed: the first cases diagnosed in 1983, systematic control of blood donors from December 1985 onwards, declaration as a public health priority in 1986.

At that time, a national survey estimated the HIV infection rate at 3% of the total population. Despite considerable efforts by the Ministry of Health and its specialist body, the National Programme to Combat AIDS, with financial support and logistic advice from a number of international agencies, the disease has progressed inexorably, not reaching a plateau until 1990. This leads us to estimate the number of persons infected today at more than 300,000, or at least 4% of the population. Among these we must include some 130,000 women of childbearing age, and undoubtedly more than 20,000 children.

But the most painful problem is perhaps that of the orphans: of whom there are an estimated 62,000 so far, a figure which could rise to 150,000, or two inhabitants per 100, by 1997! The situation of these orphans is rendered very difficult even before the death of their parent(s).

The latter see their physical forces diminish irreversibly, making any work impossible. Moreover, only 20% of sufferers have stable jobs, the vast majority being either unemployed, or reduced to doing small jobs. Thus, the declaration of AIDS leads simultaneously to a loss of income and an increase in expenditure (health care), hence an impoverishment from which the whole family suffers, starting with the children: lack of schooling, unbalanced diet, and lack of medical care in particular. At times, the family even loses the roof over its head. Of course, there is no social security coverage in Africa as we know it in industrialized countries.

Children of single-parent families: a precarious social status

The problem is all the more acute as only 16% of these children are fortunate enough to have legally married parents. 46% of these in fact live in «common law marriages», and very frequently these couples, already unstable and fragile by nature, separate once the terrible curse of AIDS strikes. The remaining 38% of families are headed by «single mothers», women who are separated or living alone, victims of the «second family» practice, the remains of polygamy, or condemned by their lack of training (half of them are illiterate) to occasional, but high risk prostitution, in order to sustain themselves and their families. The social status of the children born of such persons is particularly precarious: their very existence is not always legalized, since they are rarely recognized by their father and they are not always inscribed on their mother's identity card. This makes schooling difficult: almost one-third have never attended school.

All this contributes to increasing the lack of love and security which these children suffer from, their anxiety as to their future, not to mention fantasies of death which at times perturb them.

Finding themselves alone, they often have no links with their mother's family, living in the interior of the country, whilst they are born in the city, a family which preferred to ignore their existence because their mother was unmarried.

Finally, the war which has ravaged Rwanda since 1990 has

* Director of Caritas Rwanda, B.P. 124, Kigali, Rwanda. Original in French.

further accentuated the separation between the members of split-up families, and reduced orphans' hope of being looked after by their wider family. The grandparents, even if these children have frequently not been presented to them according to local custom, would at times be ready to look after their grandchildren, but when they themselves can barely survive due to the privation caused by the conflict, what can they do? In certain cases, these orphans attempt spontaneously to find a «foster family» in which they might feel more looked after, understood and loved. Such a search is generally doomed to failure.

The socio-economic context of present day Rwanda scarcely promotes solidarity: as in every area, the irrational fear provoked by AIDS includes that of taking in orphans. This would require a population which is much better informed than it is, and getting across the message that the risk of contamination through these children is non-existent or negligible. Moreover, only 10% of them are virus carriers: most of them having been born before their mothers became infected, or having had the good fortune of not being infected in the womb or during the peri-natal period. But this does not alter the fact that families are unwilling to take the risk of accepting these orphans into their homes.

Caring for AIDS orphans

Of course, economic decline, high unemployment, successive devaluations and consumer price inflation provide little encouragement to families, who are frequently numerous themselves, to take in these children when they have difficulty in feeding their own. The cost, including food, school uniforms, health care and school fees, is far from negligible for an average Rwandan household. Experience shows that it is more often women living alone (widows or divorcees) who accept to take care of these children. In many other cases, the organizations which are attempting to channel this problem call on the goodwill of older brothers and sisters, once these have reached an age which permits them to look after their younger siblings. But it is obvious that these solutions, which appear ideal as they do not separate brothers and sisters of the same family, stumble against the often limited sense of responsibility of those to whom the guardianship of the younger children is entrusted, and prevents these from receiving the education which they need.

The war has further reinforced the tendency towards egoism and has accentuated economic problems. Moreover, the population movements which it leads to, even when they carry the seeds of hope, like the present return of displaced persons to their homes after months of exodus, are also further vectors for the export of AIDS. All these populations, who have been temporarily parked in camps in frightening conditions of promiscuity, are going to return to their home provinces with HIV which is the cause of these orphans' misfortune.

We cannot pass over in silence the effort made by traditional orphanages to confront the problems posed by these children. In Kigali and elsewhere, most institutions accept AIDS orphans, in most cases even when they are HIV-positive. Unfortunately, they have all largely exceeded their capacity to take in new children, and the influx continues. To make the misfortune worse, the few western families who take the risk of adopting these little Rwandan children in general take great care to ensure that the child is not linked to AIDS.

Hence the urgent need in Rwanda, both to increase the ability to look after children, and for an effective structure for analysing each individual case and guiding the child to the type of solution best adapted

to his/her personal situation. In the latter area, medical-social centres, like that of Bilyago in the suburbs of Kigali, have an essential role to play in the permanent monitoring of AIDS victims' families. They are in a position to identify in time the needs of present and future orphans and to find the best placement possibilities.

The Family Homes Project

However, this is becoming increasingly difficult at a time when the progress of the epidemic is leading to a rapid increase in the number of these children. This has given birth to the Family Homes Project, carried out by Caritas Rwanda with the support of the Rwanda Ministry of Health, which has included it in the second medium-term plan (1993-1997) of the National Programme to Combat AIDS.

Conceived in 1991, this programme only really got off the ground in 1992, and is currently in a growth phase, being limited only by budgetary constraints.

In fact it constitutes an extension of the more general programme of caring for AIDS-affected families which has been undertaken by Caritas Rwanda since 1989. In addition to a psychological counselling service, the programme offers various forms of assistance: food, supply of basic medicines, payment of school fees, funeral expenses.

The family homes are structures designed to give orphans a background as similar as possible to that of the family which they have lost. Each of them consists of between 7 and 10 children, boys and girls, aged up to 16 and sometimes older, looked after by a «mama» who feeds them, but who is also the biological mother of some of them, as recruitment is directed first and foremost at single women with children.

Caritas takes care of buying and equipping a house in the Kigali suburbs, or in one of the various provincial towns.

These are small simple but clean houses, equipped with the basic necessities. The mother is given a budget (100 Rwandan Francs, i.e., FF 4 or USD 0.70 per day and per person) enabling her to cover autonomously the ongoing expenses of the household: food, clothing, maintenance, water and electricity.

From now on, the orphans received in these family homes pass a HIV-test, with the sole aim of being able to provide them with care without waiting for symptoms to appear. Otherwise, HIV-positive children are enabled to lead, as far as their state of health permits, the same life as their healthy comrades. All children of school age attend school, which also enables them to integrate better into their social environments. Otherwise visits are rare, even from the enlarged family which has forgotten them. In this way, these family homes offer these children a minimum of material comfort and love to which they are entitled, in the absence of foster families which are becoming increasingly rare, as well as the training on which their future depends.

When a serious health problem arises, the orphans are treated at the medical and social centre, and then possibly at the hospital. Nonetheless, this solution is not totally satisfactory, as it creates profound ruptures in the children's lives.

For this reason Caritas Rwanda is hoping to be able to open soon a care centre to look after all those needing permanent treatment. There they will be able to benefit from the permanent presence of a nurse and an additional outside social worker. This project is currently being implemented.

Today, only a few hundred children are being looked after in this way. At the time when Rwanda has just set itself the ambitious objective of assisting, by 1997, 50% of its AIDS orphans, we can measure the gigantic effort which remains to be undertaken, both by the Rwandan community, whose children they are, as well as the international community, whose financial assistance is manifestly necessary. Let us hope, for the sake of these totally innocent victims of the AIDS curse, that this challenge will be rapidly met. ❑

Italy

A Home for AIDS Orphans

The Group "Giovani e Comunità"

Fr. Bruno FREDIANI*

The group "Youth and Community" in Lucca is a voluntary association, founded in 1976 to provide assistance and rehabilitation to children in difficult circumstances, in particular those addicted to drugs.

At the present time, the group runs a certain number of prevention projects in the area, as well as various host and therapeutic communities, a family home for AIDS victims and one for children whose families have been affected in one way or another by AIDS.

Working with drug addicts, we encountered the problem of being HIV-positive and the various other problems related to this illness. We were also faced with cases of children born HIV-positive, orphans of parents who died of AIDS, or who have suffered in one way or another as a result of the disease and of the parents' way of live.

Welcoming the first AIDS orphans

The first case was presented to us by the local social services back in 1990. It involved two brothers, Giovanni, aged 10 and Filippo aged 7. Their mother had died a few days before from AIDS and their father was a drug addict and HIV-positive.

The children are not HIV-positive, but suffer psychologically from their parents' disorganized lifestyle throughout the years, with memories of violence which they endured, being left alone at home for long periods time, or placed with relatives and friends during their mother's stay in hospital. Giovanni, the elder, is seriously autistic, communicates with great difficulty, and has at times a somewhat violent attitude.

Filippo is a vivacious young boy, loves company, and is affectionate. Both of them have lost a lot of schooling due to the long absences from school during the time they were in their family. These absences were caused also by the fear and social refusal of the parents of the other children in the school, who, knowing their family situation, feared that they were carrying the infection.

Shortly afterwards, we had the case of a girl of 26, a drug addict, who had contacted us several times in order to attempt to get off drugs, but who had never had sufficient perseverance to complete the programme, and after some time always escaped from the community. Then, having become pregnant, HIV-positive, and having certain symptoms of the disease, she wanted to have her baby at all costs, seeing in this choice the possibility of becoming rehabilitated and giving a positive meaning to her life. We took her into our home, and after four months she gave birth to a lovely little girl, who is now nearly two years old and who is HIV-negative.

Since then the social services and the children's court have entrusted us with four other children. At the moment, there are 7 children in the family home. The mothers of two of the smallest children, Lucia, aged 2 and Sonia aged 4, also live with us, whilst the father of one of them, Francesco, aged 10, is often with us, as he is undergoing a drug dependency rehabilitation programme in one of our communities. The other children are two pairs of brothers who have sporadic contacts with their parents and families.

A village community is involved in the project

The community is situated in the parish house of a hill village of 120 inhabitants, whilst the house also acts as a centre for the other village children. Together with the parish priest, the writer and the guests, it also houses another family, a husband and wife with a daughter aged 23 and a son aged 18, both students. The other families in the village are involved. They are aware of the children's situation and have overcome with serenity the fear and prejudices which always surround such cases.

The children attend school in a local village to which they travel, with the other village children, in buses provided by the local authorities.

*Responsible of the Project AIDS Orphans.

For information: CESERS, Via S. Giustina 59 - Lucca, Italy. Tel. (39-583)56095; Fax (39-583)419590. Original in Italian.

Brazil

The Children of the Day After

Gabriela O'Connor*

Even though it is one of the world's ten largest economies, Brazil has 35 million people living in conditions of starvation and absolute poverty. Already stricken by many endemic illnesses, this population is now further threatened by AIDS which, according to official estimates, has already affected more than 600,000 people. Contamination is particularly rife among the active population (20 to 45 years of age), and with children aged under 15.

Both inside and outside Brazil, the AIDS which is spoken and written about, is that which affects the middle class, and which is as painful as any other version, but not as humanly dramatic in its consequences as the one which affects the poorer population. Here, the effects are more inhuman: it robs its victims, in a single blow, of their one source of survival: work. Without work, they lose their right to housing, food, clothing and a family. Ignorance and the lack of information - the breeding ground of prejudice - leads to social exclusion, feeding the discrimination, with as a consequence lack of proper care and a premature death. A death which leaves its roots in the "children of the day after". Who wants them? Who will look after them? Their parents' AIDS kills off all prospects for the future for the children they leave behind. If life for them was already difficult with their parents, it will be worse without them.

In Brazil, no serious and complete studies exist on the subject of AIDS orphans, making impossible a more scientific assessment of the present situation and a reliable forecast on which to base more global initiatives in the future. The result is that concern with this question is found essentially at local levels. Initiatives for solutions are still timid, even heroic. Of one thing we are fully convinced: AIDS orphans will have a social impact of unforeseeable proportion.

Which solutions for AIDS orphans

The solutions offered at present are either extremely precarious or totally inadvisable. Faced with the orphaned children, close relatives will entertain the idea of assuming the care or adoption of these minors. But the economic impossibility of maintaining them becomes a prohibitive factor, in particular when only with heroic efforts are they able to provide the minimum for their own children. Those who do accept this burden,

* Director of the project Esperança de São Miguel Paulista São Paulo, Brazil - Fax (55-11)956-5570. Original in Portuguese.

moved by the family instinct, are generally paternal or maternal grandparents. But to succeed in this task is nothing more than a miracle. Grandparents often more than 70 years old, surviving on criminally exiguous pensions, end up taking in these children, which only protects them for a short time from the fatality of total abandonment.

The few private orphanages, created by the concern of a few, and maintained by erratic collecti e generosity, lack any prospect of expansion.

Adoption processes are legally complicated, tedious, and normally end up destroying the goodwill and initial interest of potential adoptive parents.

There remains the institutional solution of state homes. Good sense and experience advise against such confinement, which historically has contributed more to exclusion and revolt than the social readjustment of the children entrusted to them, as proven by the constant collective rebellion of these minors, and a constant general tone of violence and depredation.

The passivity of governmental organizations is criminal and NGOs' initiatives still insufficient to confront this problem adequately. To illustrate this, it is enough to cite our 5-year experience of accompanying AIDS patients in their homes on the edge of the city of Sâo Paulo. Working in an area where HIV contamination is high, the Sâo Miguel Paulista Esperança project currently looks after some 450 persons. Most of them married, these persons, will, on their deaths, leave behind them 230 orphans aged under 15. Of these, 6 are virus carriers, 200 are prove HIV-negative. The situation is further aggravated by the fact that a dozen or so of these children have physical and/or mental deficiencies. This picture is tending to worsen rapidly. In the last 6 months, we have recorded an average of 25 new cases, and an average of 10 deaths a month.

"Long distance sponsors"

The lack of options has forced us to venture onto new paths which, even if not final solutions, at least serve to reduce so much suffering in the short-term. Right at the moment we are starting a campaign to motivate persons to become "long distance sponsors": promising to guarantee monthly economic aid to maintain children taken in by close relatives of persons who have died from AIDS. The campaign "Kiss a child victim of AIDS" will attempt to sensitize society as a whole to the situation and to sharing the challenge of avoiding the abandonment of the "children of the day after", giving them a minimum of dignity, a right belonging to all citizens.

We believe that it is up to those NGOs which are committed to life, to stimulate collective solidarity to solve short-term problems, to put pressure on government authorities to overcome their political blindness and social insensitivity, and to take initiatives to ensure, in the long-term, the right of full citizenship for AIDS orphans.

Only in this way will children who are directly or indirectly victims of AIDS, be able to look forward, without fear, to the Day After, with a minimum of decency and dignity.

United States

AIDS and Familes

Farano Center

Suzanne VAN ALSTINE*
Karen LAQUIDARA-DICKINSON*

Community Maternity Services, an agency of Catholic Charities of the Albany Diocese responded to the needs of children infected by HIV. A transitional residence, Farano Center for Children, was opened in 1987. The experience of working with infected children underscored the importance of a coordinated care system and prompted the agency to expand its services to families in the community living with HIV.

Maintain for as long as possible the integrity of the family

In 1990 Community Maternity Services developed Farano Program for Families. Our challenge with these families has been to maintain the integrity of the family unit for as long as possible, to accept them as they are, and to journey with them. We provide support, we assist with permanency planning for children, we advocate, we coordinate services, and we provide therapeutic counseling. We help families cope with the loss of hopes, dreams, trust and self-esteem while they adjust to changes in physical health. We assist in planning for their future and saying goodbye. Our services are family centered and we work with the strengths and resources of each family, assessing their needs and prioritizing services. Our services are multifaceted and flexible enough to respond to the many and repeated crises a family endures.

Vulnerable children

Children within these families are the most vulnerable due to the stressors placed upon the family system by HIV. Healthy siblings, often the forgotten, carry an inordinate burden of responsibility. When aware of a parent's or sibling's diagnosis, healthy children sometimes imagine the worst if they are not included in what is happening. They act out with negative behavior. They are often locked in a web of secrecy, not able to share with their peers for fear of rejection. They begin to experience a loss of childhood. They may become parentified and assume responsibility for their parents or younger siblings. Having to deal with the death of a parent or sibling raises issues of abandonment and permanency... "What is going to happen to me?" "Where will I live?" "What will I tell my friends?" "When can I say goodbye?" Many of the feelings that adults grapple with regarding their illness (denial, anger, fear, confusion, worry, acceptance) are experienced by healthy children. Furthermore, after the death of a

* Farano Center, New York, USA.

sibling or parent, the remaining child may express a death wish as the child doesn't understand the permanency of death and longs to be with the loved one.

To address these concerns, Farano Program for Families, has developed a Children's Program - a safe environment that allows healthy children the opportunity to talk about HIV as well as to teach them the skills that they will need to cope with the greatest loss one can experience - the loss of a parent, sibling or other close relative. To participate, the child needs to be aware of a parent's or sibling's diagnosis. We stress to parents the importance of disclosure of the HIV diagnosis. There is no perfect script. They need to listen to the child and the child will give the clues. Honesty is the key.

We focus on self-esteem, trust building and the identification and labeling of feelings through a variety of mediums (art, writing, games, videos books, discussion). Children are allowed to share with each other their concerns, worries, confusion, sadness, fear, anger, and grief. The program is a process. Patience and time are important ingredients. The long range goal is that children will be able to appropriately grieve their losses in a healthy manner and receive support. They will learn to commemorate. Hopefully, children will become less parentified and will recapture their childhood. They will come to learn that the stigma placed upon their families by society is unjust and incorrect; that they are unique, special individuals. They will not live in shame because their family is affected with HIV, but will carry with them a legacy of concern and love.

For information: Farano Center, 27 North Main Avenue, Albany, New York 12203, USA; Tel. (1-518) 482-8836; Fax (1-518) 482-5805.

World Health Organization to Administer New U.N. Programme on AIDS

In a resolution adopted on 21 January 1994, the Executive Board of the World Health Organization (WHO) has recommended the establishment of a co-sponsored United Nations Programme on HIV/AIDS. The aim of the Programme is to achieve global coordination of policies, approaches and funding in the urgent struggle to slow the spread of the disease. The Programme is to be administered and located in WHO.

The Programme will bring together six United Nations organizations: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Educational, Scientific, and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the World Bank and WHO.

The main objectives of the new UN programme are:

- to provide global leadership in response to the pandemic;
- to advocate greater political commitment in responding to the pandemic;
- to provide technical, strategic and policy direction;
- to ensure collaboration among UN system organizations, governments and non-governmental organizations;
- to strength the capacity of governments to coordinate and carry out HIV/AIDS activities.

Extract from Press Release WHO/6/21 January 1994.

For information: World Health Organization, CH - 1211 Geneva 27/ Switzerland - Tel. (41-22)791 21 11; Fax (41-22) 791 07 46.

Zambia

Anti-AIDS Clubs

Dr. Kristina BAKER*

All over Africa, children are now recognised as an important target group for AIDS education but this recognition came slowly. The first AIDS campaigns in Africa were targeted at "high risk" adult groups, such as sex workers. Then we realised that the whole sexually active population was potentially at risk; campaigns had to be targeted at all the different sectors of the population.

AIDS education for children who were supposedly not yet sexually active was at first resisted on moral and traditional grounds. It was feared that AIDS campaigns could encourage sexual experimentation. In particular any mention of condoms met with hostility. The traditional view was that only elderly relatives should discuss sex with children and young people but this has changed and many African countries now have children's AIDS programmes.

The Anti-AIDS Project in Zambia was one of the first. It had humble beginnings - a discussion with 80 secondary schoolboys in a small class room in Lusaka one hot afternoon in February 1987. I had no budget, no funding, no materials and no plans for further talks! The boys responded with great interest and many intelligent questions. A few days later, I talked to several hundred schoolgirls who were equally concerned and interested. They asked for reading materials on AIDS and HIV but nothing suitable was available, so I started to write a pamphlet dealing with their questions. NORAD, the Norwegian aid agency, offered funds for duplicating, further talks

* Anti-AIDS Project. For information contact the Anti-AIDS Project, Private Bag 75X, Lusaka, Zambia.

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were requested and so the project was born.

The first Anti-AIDS Club

Later in 1987, a schoolboy asked for help in starting an Anti-AIDS Club. I had been suggesting that children could start such clubs in their schools and communities. This schoolboy had lost several relatives and was worried about AIDS, so he wanted to warn his friends. We worked out club promises, rules and possible activities, and he set up a club committee. This first Anti-AIDS Club was in a boys' boarding school in Lusaka with students from all over the country; when club members went home for holidays they talked about AIDS with their friends and extended family members. So the idea spread and more clubs were formed.

By the end of 1992 approximately 1,500 clubs had registered with the project. Club members promise to avoid sexually transmitted HIV themselves (by chastity before marriage and faithfulness afterwards), to teach their friends about HIV and AIDS and to help people who are infected or ill. Club registration, membership and AIDS information is available free from the project.

Later we developed the following guiding principles for our work:

- No one should be allowed to die of AIDS through ignorance.
- AIDS education is most likely to be effective and to result in sustained behaviour change if it is done by young people talking to their friends.
- Every young person needs access to suitable written AIDS information.
- Education about condoms is necessary, but chastity followed by mutual faithfulness in a lifetime sexual relationship is the safest way to avoid HIV infection.
- The time to start AIDS education is now, the place to start is here and the person to do it is me.
- People with AIDS or HIV should be treated with courtesy, kindness and care, as we would like to be treated if we were infected.
- We should cooperate with all other organisations seeking to teach young people in Zambia about AIDS and should share our resources; all our material should be free of copyright.

Turn young people into community educators

These beliefs were translated into action by the project staff and many thousands of young Anti-AIDS Club members all over Zambia.

The idea behind the Anti-AIDS Clubs was to turn as many young people as possible into knowledgeable, committed voluntary community AIDS educators. We worked from the bottom up rather than the top down, giving motivated children and young people the information and materials they needed to stay safe themselves and to teach their friends. The clubs became popular and well-known, providing peer support for children concerned to stay save from HIV as well as accurate unbiased information about AIDS.

When club membership was analysed in February 1992, 1,150 clubs had nearly 40,000 members at registration, 44% girls and 56% boys, and 88% of clubs had mixed membership. 49% of the clubs were school-based, half primary and

"There is an urgent need to be creative and inform young people about AIDS - by taking care to provide them with the pedagogic support necessary to safeguard their own sense of initiative. By calling on capable adults to help them assimilate this information properly with a view to adopting responsible attitudes, the tough social ordeal constituted by AIDS may promote maturity and the human and spiritual progress of adolescents. This epidemic is laying down a challenge for us: the educational world must prove itself creative, released from fear and sincere as regards its declarations. The results are worth it."

(Bernard Matray, Dept. of "Ethique biomédicale du Centre Sèvres", Paris, France. Extract, Etudes, Feb.1991)

half secondary, 5% were based in tertiary institutions and the rest were community-based.

Respond to the children's concerns

The work of the Anti-AIDS Project is varied and responds to the children's suggestions and concerns.

• We produce and distribute free **materials** to four main groups: upper primary pupils, children out of school ("drop-outs"), secondary pupils and students in tertiary institutions. We send bulk supplies of materials to institutions and answer individual letters (1,500 letters a month on average). More than two million **leaflets** and **booklets** have been printed. Ten different **posters** have also been produced. We produce club membership cards, AIDS information in seven vernacular languages and information for Christians and Rastafarians.

• We encourage the formation of Anti-AIDS clubs. A club is usually started by a concerned young person, in or out of school, who writes to the project for a free "registration pack". Each club receives a newsletter and new AIDS education materials every term. Every member gets a free membership card. A club magazine or colouring book and calendar is produced every year. Information about cholera, drugs, alcohol, smoking, STDs, fertility, World AIDS Day, World Health Day, etc., is included with the newsletters.

• We hold national competitions to raise AIDS awareness among young people. These have so far included a colouring competition and competitions to design a club logo, a slogan, a game, a book cover, a T-shirt, a poster, a rap, a billboard, and an illustration of a World AIDS Day theme. Many project materials, slogans and designs are based on ideas from club members.

• We produce and sell (at subsidised prices) novelty items printed with AIDS slogans. These are sold to club members and the general public and used for prizes. T-shirts, badges, mirrors, calendars, paper hats, games, book covers and stickers are made locally, pens, pencils, rulers, footballs, key-rings and carrier bags are imported.

• We visit Anti-AIDS clubs in and out of schools wherever possible. We also ask Community Theatre groups travelling on tour and other local organisations to visit and encourage clubs. We run holiday programmes and discussion sessions for children.

• We run a small AIDS resource library for club members, club patrons, health workers, researchers, etc., with materials obtained locally and from abroad.

Other countries have expressed interest in project materials and the Anti-AIDS Clubs. We have shown that young people in Zambia are willing to join such clubs. Frequent monitoring and efficient communication between the clubs and the project office are necessary to make sure the clubs are disseminating correct up-to-date information and members do not lose interest. In one survey of 792 Zambian secondary school students in 1992, 10% said they were Anti-AIDS Club members; a mini survey found that they had better knowledge about AIDS than non-members and great awareness that they themselves could be at risk, and all the boy members felt that chastity was a possible option for unmarried men.

We found it difficult to assess changes in sexual activity accurately; schoolgirl pregnancy rates and teenage gonorrhoea inci-

dence would probably give the best objective evidence but we could only get anecdotal suggestions of a reduction in either. The local blood bank director told us after a campaign to encourage club members to give blood that their HIV rates were lower than the average for their age group but we could not get accurate statistics. Any impact on AIDS deaths will not be seen for years because of the incubation period of HIV.

This type of project is expensive and relies heavily on donor funding. It is based at the individual and community level and specifically targets young, mostly uninfected people who will be leaving school, seeking work and starting families in the next few years. It is thus targeted at an economically strategic sector of society and we believe will turn out to be cost effective. The clubs will also give young people a number of friends of the opposite sex who have identified themselves as concerned to stay safe from HIV and willing to delay sex until marriage; it may become an unofficial marriage bureau! We had many letters from older club members who had left school and wanted to start community or workplace clubs, this was encouraging.

Young people everywhere have the right to know the truth about AIDS and need unbiased factual information. They can then make their own decisions based on the facts, and in turn educate their friends. The Anti-AIDS Project supplies AIDS information and Anti-AIDS clubs support and encourage those who choose abstinence and faithfulness as the safest way to avoid sexually transmitted HIV. We also give detailed information about condoms to those who choose to use them. In Africa, what is at stake is nothing less than the survival of the next generation.❑

Lesotho

The Mokhotlong child shepherds workshop on AIDS

The Lesotho Catholic Bishops' Conference drew up a 3 year national Church-related programme for HIV/AIDS prevention almost 2 years ago.

Initially concentrating on awareness-raising among health workers, including those working in villages, the **focus** expanded to teachers and pupils, pastors and parish committees, migrant and women's organisations, and young people. Several workshops and seminars were organised by the staff of the Commission for Health and Social Welfare who moved systematically from diocese to diocese. It soon became obvious to the staff members involved that one neglected group was that of the **shepherds** of Mokhotlong.

Mokhotlong is situated in the northern part of Lesotho, a 10 hour drive fron Maseru. It is a moutainous area and can be extremely cold. The shepherds are children (boys) who spend their time out on the mountains herding sheep and goats. Arrangements were made to have an eight day preparation for World AIDS Day involving some 400 shepherds in Mokhotlong.

The AIDS Coordinator lived with the shepherds' **parents** so that preparations could be made in a **participatory** fashion. The shepherds were taught the basic facts about HIV/AIDS, its prevention and care of people with HIV-related illness or with AIDS.

Over 400 shepherds attended, despite the fact that some chiefs initially refused to allow their sherpherds to attend. However, on observing the presentation made by those who were attending the workshop, they later sent their children to attend the World AIDS Day celebration. **The boys entered into the celebration enthusiastically** : singing songs, asking questions about HIV/AIDS, and performing traditional dances. They were also interviewed by reporters of Radio Lesotho. The people from the area were very enthusiastic about the celebration and asked to have it repeated annually.

Excerpt : AIDS and Developement, CAFOD Information pack - London, Great-Britain.

World Organization of the Scout Movement

Action for Youth

AIDS Training Manual

The World Organization of the Scout Movement has been running health promotion workshops for some time. The workshops are designed to help Scout leaders develop skills in organizing and implementing community health campaigns. AIDS health promotion can build on the work that Scouts have already accomplished in health education for the Scouts themselves and their communities.

The League of Red Cross and Red Crescent Societies and the World Organization of the Scout Movement came together to develop this manual. The manual is intended to be used by youth leaders in National Societies and Scout Associations to continue their AIDS health promotion programmes.

The material in this manual has been written for youth workers who work with young people in their mid-teens and older.

This pack has been designed to :

- Provide information about AIDS and how to prevent the spread of the HIV.
- Help to deal with worries and concerns related to HIV infection and AIDS.
- Suggest a method for planning and evaluating an AIDS health promotion programme for youth groups.
- Present activities to try with young people to help them make healthier and safer life choices.
- Give ideas for community services projects related to AIDS health promotion that can be carried out by the youth in a group.

The development and implementation of AIDS health promotion can be the strarting point for general health promotion programmes.

The ideas, activities and techniques presented in this pack can be adapted to other health topics for use in general health promotion programmes.

For information : World Organization of the Scout Movement, P.O. Box 241, CH-1211 Geneva 4, Switzerland Tel. (41-22)320 42 33 - Fax: (41-22)781 20 53.

To parents and educators

"The real cure for AIDS"

«Dissociated from love and fertility by the widespread use of contraceptives, sexuality is often reduced to pleasure. Instead of communication and the gift of oneself, there is a withdrawal into oneself, a retreat». (...)

Is this really all that we have to offer young people as an ideal? How can young people discover love and faithfulness in future? How can they establish a solid family? Scarcely freed from theoretical materialism, they are pushed towards practical materialism, idolising money without admitting it and sex, glorying in it. What if, by dint of focusing happiness in the senses, we have lost the meaning of happiness? (...) The real cure for AIDS is love, and the real means of prevention is modesty, and respect for oneself and for others.

It is human respect which is at stake. Is it not infinitely greater for man to help others grow in true freedom and love without encouraging them to «make love»? Is forcing the rising generations to take the easy way out not the same as despising them? To believe them incapable of understanding that sexuality and love are great things and that they have to be prepared to pay for them - is this not the same as despising them? Teachers who have the courage to propose this solution to young people confirm the truth of it every day.»

Mgr. Julien, Archbishop of Rennes, France. Extracts from "Le Monde", 21 Oct. 1992.

AIDS Education Video

Karate Kids

Christopher LOWRY*

The animated action-adventure video **"Karate Kids"** is part of a cross-cultural HIV/AIDS education programme for street children developed by Street Kids International in cooperation with the World Health Organization, the National Film Board of Canada and other partners. Created to fulfill the need for simple, explicit AIDS health education for street youth in the developing world, the cartoon is now in distribution in seventeen languages, being used by educators in over 100 countries. The package includes the twenty-two minutes karate adventure cartoon on video, a training book for educators, and a pocket comic book. **"Karate Kids"** is shown in community centers, in theatres, out of the backs of trucks, in hospitals, schools and prisons. In Thailand alone 3,500 copies of the cartoon are in distribution, and 2,500 street workers have been trained by the Thai Red Cross to use the cartoon in a group discussion.

As **"Karate Kids"** is distributed primarily in video format, it is easily copied - which is encouraged. In 1993 Street Kids International has received requests for five new language versions, including Russian and Cantonese. An advantage of the cross-cultural format established by "Karate Kids" is that it can be easily adapted to new language versions, independent of the original producers.

After three years in distribution, field evaluation has shown that the greatest strength of the "Karate Kids" video is that it stimulates discussion, often where no discussion was taking place before. Educators in Brazil, Mexico, Canada, Tanzania and Thailand report that the cartoon stimulates lively dialogue about sexual health, street life, and AIDS, often for the first time.

Treat street kids with respect

"Karate Kids" has provoked some criticism, first, from authorities who do not accept the need for this kind of sex education for youth, and second, from people who feel that it should stand alone as a comprehensive AIDS education "lecture" on video. One evaluation study of the immediate impact of the cartoon on knowledge and attitudes of children indicates that "Karate Kids" alone does not provide a complete AIDS education lesson. On the other hand, a cross-cultural Participatory Evaluation Survey indicates that significant impact on knowledge and attitudes is achieved when there is opportunity for a discussion after showing the video.

A subtle but significant contribution to this project to development communications is not only that it teaches street kids things that they need to know, but that it treats them with respect, in a voice that they can relate to on their own terms. It acknowledges street children as actors rather than victims, with legitimate needs and rights, rendering them visible in a world that too often ignores them.

* Director of Communications, Street Kids International. Excerpt from a feature article written for Development Communication Report, No.81, International Research.

For information: Street Kids International, 56 The Esplanade, Suite 202, Toronto, Canada M5E 1A7 - Tel. (1-416) 861-1816; Fax (1-416) 861-9386.

Philippines

Pilot Project on HIV and AIDS Education and Prevention

The project set up by Christian Children's Fund-Philippines and STOP Trafficking of Filipinos aims to identify cultural practices of young people which may have bearings on their sexual practices and information on how they think and feel about HIV and AIDS. The baseline study found that a number of young adults shared common misconceptions about boy-girl relationships and sex; therefore, there is a need to clarify these concepts and develop self-awareness in order to promote sound and healthy attitudes toward interpersonal relationship and sexual behaviors. The study also found the need for young people to undergo training as a strategy for information dissemination and acquisition of right information and/or expand knowledge to deal effectively with current realities including HIV/AIDS and human sexuality. This baseline information is used to design intervention and communication packages composed of training modules, posters, and other materials that can be used for an educational program for youth. This project was supported by the National AIDS Prevention and Control Program of the Department of Health in the Philippines.

Childhope Asia Newsletter, 1210 Peñafrancia Street, Paco, 1007 Manila, Philippines.

Child-to-Child

A Different Approach to Health Education

Child-to-Child Activity Sheets are a resource for teachers, and health and community workers. They are designed to help children understand how to improve health in other children, their families, and their communities. Topics chosen are important for community health and suit the age, interests and experience of children. The text, ideas and activities may be freely adapted to suit local conditions. The activity sheet on AIDS gives explicit facts about how HIV is caught and how it can be prevented. It also looks at people's attitudes and practices concerning AIDS. It aims to develop in children, their teachers and their families an openness to discuss these sensitive issues, a confidence to take decisions for themselves, and a sense of caring for people with AIDS.

For information : Child-to-Child, Institute of Education, University of London, 20 Bedford Way, London WC 1H OAL, United Kingdom.

Education for Life

A Behaviour Process for Groups

Kay LAWLOR*

This program is designed for use with groups who are living in an area where there is a high prevalence of HIV infection and a need for safe sexual behaviour. Depending on the age and experience of the individuals in the group, it aims at either reinforcing present safe behaviour or bringing about a change in behaviour. In either case, it is the individuals in the groups who choose the appropriate behaviour and then commit themselves to it. The group and its leader simply facilitate this.

The process is based on the "helping skills" model of Egan**, a behavioural and problem-solving model. This was chosen because the prevention of AIDS requires behaviour change in most cases and this is not easy to achieve. It does not happen simply by giving people information about the disease. This process is designed to facilitate a person's movement through the various stages of behaviour change: identifying the problem, choosing goals, and planning action. In the "Education for Life" program, the model is used to help individuals examine their lives and especially their sexual behaviour, determine what behaviour is safe and possible for them, and then commit themselves to action. The group support helps in clarifying the problem and increasing commitment.

A dynamic process

It is important to note that "Education for Life" is a process. This means it is dynamic and there is overlap of the various stages.

To facilitate the use of the program, guide questions are prepared for each stage and step. These are adapted to the specific group. A diagrammatic format has been adapted; each step with its guide questions is on a different page. The group leader uses this as a guide for the discussions. Other questions may be added at any time.

There are many ways of using this program; much will depend on the age and needs of the group as well as the time available for meetings. It requires a willingness to meet and to share. And it needs committed and prepared group facilitators. They need to have a knowledge of HIV infection and a belief that behaviour change is possible. They are then helped to understand how behaviour is changed and trained in individual and group helping skills. The length and type of training will depend on the prior skill of the leaders. Once trained they are encouraged to adapt the questions and the program to their particular groups. In most instances groups meet for an hour once a week. However, the possibilities are as numerous as the groups that will use the program.

The prevention of AIDS requires either the reinforcement of safe behaviour or the change of

* Kitovu Hospital, Uganda. Compilation of workshop notes and work sheets for use in training facilitators.

** Egan, Gerard, "The Skilled Helper", Brooks/Cole Publishing Company, Monterey, California, 1986.

ENDA-Tiers-Monde

Combatting AIDS multi-dimensional programme

Since 1985, ENDA has been making efforts to draw the attention of its partners to the importance of taking action against AIDS. From 1986, in conjunction with various international programmes including those of the WHO and the Red Cross, and afterwards with the national anti-AIDS committees, action to prevent AIDS was undertaken by ENDA in several parts of the Third World, mainly in Senegal and Côte d'Ivoire. The aim was to provide the groups and categories of people most at risk, as well as the public in general, with information on AIDS.

Methods were tested, improved and applied to the various socio-cultural groups, depending on their special needs. While continuing with the work under way, other activities are being developed in other Third World countries where ENDA is involved, such as Mali, Zimbabwe, Madagascar, India and the former Indo-Chinese countries.

Cassettes in vernacular languages

In India, for instance, the ENDA group in Bombay attempted to identify the delicate aspects of the fight against AIDS. Young girls are recruited in Nepal and taken to brothels, mainly in Bombay and Calcutta. The information efforts of Indian organisations and the government rarely reach them because of language and cultural problems. So the Bombay group collected Nepali songs and replaced the words with texts explaining AIDS. These were recorded on cassettes and distributed in places where young Nepali girls are exploited as prostitutes.

A rap video-clip

In Senegal, the video «Stop AIDS» is proving very successful. To increase the impact on young people, the director Amadou Diallo used a fashionable type of music - rap - and called upon the services of talented young people voluntarily engaged in the fight against AIDS (singers, dancers, actors, youth organisations, etc.). Adolescents from urban areas, secondary and primary school pupils and young street youth are all touched by the images, rhythm and story - that of a young person who died of AIDS, whose childhood friend, the rapper, describes the situations which caused his disease.

Information strategy

The strategy adopted by ENDA may be represented by a pyramid comprising several stages ranging from **general awareness**, aimed at a very wide public, to specific action, aimed at special groups. This stratification is not rigid: the activities may be carried out successively, from the first to the last stage, without any particular order. Moreover, several activities corresponding to different stages may be implemented simultaneously.This method is aimed in particular at:

- integrating the fight against AIDS into socio-cultural experience, using local languages,
- involving those at whom the message is aimed in the devising and preparation of the didactic material,
- ensuring constant adjustment so that the messages have the best possible impact on the population.

For information: ENDA T.M., B.P. 3370, Dakar, Senegal. Tel. (221) 22 96 95.

unsafe behaviour - sexual behaviour, which touches a person at the core of their being. To help another person in this task requires an understanding of behaviour change processes and the building of a helping relationship. It is not enough simply to share information or to use scare tactics.

Behaviour change is difficult - Why ?

Because present behaviour is:

- **A habit** - When a person does something for a long time, he/she no longer even has to think about it. It is done automatically. To change, one has to pay attention and this takes energy.

- **Comfortable** - No one prefers discomfort; anything new requires getting used to and is usually uncomfortable at first.

- **Without-resistance** - Familiar behaviour occurs without resistance; any attempt to change meets resistance as a normal reaction.

- **Self-chosen** - The "child" inside of each person fights to maintain autonomy and resists change imposed by another.

- **Rewarded** - People repeat behaviour that is rewarded and do not repeat that which is punished. The person's perception of reward and punishment is crucial here.

How behaviour is changed

There are three major steps:

- Know and **accept** the present reality (behaviour).

• Choose and commit self to a **possible** new behaviour.
• Act !

None of this can occur withour the basic attitude that change is possible.

To help another person change, we help them move through these stages. This requires not only the belief that the person can change but also the willingness and ability to accept and support the person every step of the way, especially in **that person's choice** of new behaviour. Unless the person believes change is possible, wants to change, and finds some reward in the new behaviour, change will not occur. And unless the helper has positive attitudes and skills the necessary helping relationship will not be formed. ❑

Zimbabwe

A pastoral letter from the heads of Christian churches of Zimbabwe

Concerned about the growing problem of AIDS in Zimbabwe, the heads of denominations, issued a pastoral letter entitled «AIDS - The Christian Response». They invited all Christians and all people of good will, to help in combatting the very serious problem caused by the spread of AIDS in the country. After analyzing various aspects of AIDS (medical, social, economic...), the pastoral letter devotes a section to a message for youth and families which is reproduced hereafter.

«We have a special message for our youth, both young men and young women, to resist the fashion of the day in matters of sexuality. They should try to see their companions as persons of immense worth and beauty and not sexual objects. They should look forward to join a marriage partner of honesty and chastity and one whom they can be sure has not contracted HIV. We believe that both partners to a marriage should feel free to ask for an assurance that their future partner is free of infection, even if this may mean taking blood tests to reassure themselves. They should know that if one of the partners to a marriage has HIV, it will most likely be passed on to the other partner and future children. We are distressed when parents come to us and tell us that their children are sexually out of control and think nothing of having sexual relations with other children, or even with adults. This is symptomatic of the hedonistic permissive attitudes prevalent in our society today which are so contrary to traditional attitudes.

But are the parents themselves above reproach ? In many of our cities our people have clung to the immoral colonial programme that split up families by enticing men to work in the towns leaving their families in the rural areas. Many of our people still follow this practice for economic and other reasons... the temptation is then for the husband to have other women, as *girl friends* in town. Some of these may be infected with HIV which he then carries back home to his wife. But the main problem is lack of parental love and care for children in a divided family. (...)

What kind of an example is given to children and youth by husbands who spend a considerable part of their free time, and most of their money, in the beer halls ? How can they influence their children to grow up as responsible citizens when they see their mother deprived of company and housekeeping money and the head of the family sometimes intoxicated.

It is usually the women who come to us complaining. In addition to this anguish over their children, many of them are abused by their husbands. Full human rights for women, although now in our law, have a long way to go before realistic implementation, and this further erodes the new nuclear family structure in our urban areas on which the future rearing of many of our children depends."

For information : IMBISA, 4 Bayswater Rd., Highlands, Harare, Zimbabwe.

Preve at Scho

Chile

"Education for prevention and non-discrimination"

The Chilean Paediatric Society announced at the beginning of May 1993 that of the 24 children they were aware of who were suffering from AIDS, seven had died. Of the remaining 17, seven were of school-going age, «but do not attend school, except for one, because there is not yet a social conscience which prevents discrimination.»

If any problems arise in the educational community, the Ministry of Education will use all its authority to guarantee the right of children with AIDS to be educated.

The Minister of Education described the document on «Educational policy and sexuality» as an effort to get people to behave with greater responsibility in relation to sexual behaviour, thus allowing them to lead fuller lives.

The education policy recommends incorporating sex education and AIDS prevention into the school curriculum flexibly and in accordance with the guidelines in the educational approach of each school, and in conjunction with the families, teachers and pupils.

In the city of San Bernardo, a commune located to the south of Santiago, the municipal authorities announced their project on «Education for prevention and non-discrimination». This was in response to an incident, when a sick child was not accepted at school. Fortunately the child was integrated into another school.

With regard to Caritas Chile's activities in the field of education and AIDS prevention, a large number of students in public and private secondary schools in the country have been trained as «Adolescent Monitors». They then go on to educate and warn against AIDS to groups of children, in their school environment.

Seminars involving teachers from communes in the city of Santiago have also been organised on «welcoming fear in order to reduce the anguish felt about AIDS» which, even in the teaching sector, is very strong. It was proposed that working groups be set up to develop prevention strategies for schools and also to communicate these to other teachers, administrative staff and pupils in the world of education.

For information : Caritas Chile, Casilla 13520, Correo 21 - Santiago, Chile.

Scotland

A Christian response

An information pack primarily addressed to young people of secondary school age, teachers, youth workers and clergy.

The pack endeavours to paint a broad picture, bearing in mind the need of young people for full and accurate information - this information is complemented by what should be Christian beliefs, value and behaviour.

The Christian response after the example of Christ must be one of compassion and love.

The sessions are designed in such a way as to enable the whole course to be worked through consecutively. The sessions could also be used to support other programmes being covered in the school or youth groups.

Consultation with parents is recommended prior to the introduction of the programmes e.g., letter to parents, parents/teacher meeting, and parental involvement where it is possible.

For information : Tom Williams, SAFE Office, 24 Nicolson Office, Edinburgh, EH8 9DH Scotland, Great Britain - Tel. (44-31)662 0358.

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ol Level

UNESCO and WHO

Six pilot projects

UNESCO and the World Health Organization (WHO) are jointly undertaking six pilot projects in Asia and the Pacific, Africa, Latin America and the Caribbean to develop innovative approaches for AIDS education in schools, with the long-term objective of integrating successful educational strategies into school curricula.

The projects are being carried out through workshops for the production of educative materials and teacher training workshops. The overall goal is to help young people of school age behave responsibly, giving rightful importance to self-esteem and mutual respect.

In line with the programme's objective of focusing on technical leadership and support to help countries plan and implement effective AIDS control, plans are underway to organize regional training courses for decision makers on AIDS education in school.

For information :UNESCO, 7, place de Fontenoy - F - 75700 Paris, France - Tel. (33-1)45 68 17 43; Fax: (33-1) 47 34 77 66.

Hong-Kong

A kit for secondary school teachers

In early 1987, the Social Studies (Secondary) Curriculum Development Team in Hong Kong began to work on AIDS education which has become the concern of many educational bodies of the world. In this connection, a teaching kit has been prepared for the reference of secondary school teachers.

The main objectives of producing this teaching kit are to provide secondary school teachers with basic information for teaching about AIDS and to suggest some learning activities which would enable students to have a fuller understanding of the danger of AIDS as well as to cultivate in them healthy attitudes towards the whole issue.

The kit consist of four parts : Part I: Reference Materials for Teachers - Part II : Information Sheets for Students - Part III : Worksheets for Students - Part IV : Overhead Transparencies.

There is also an Introductory Guidebook, a sound synchronized slide set and a video cassette for illustrating the information contained in the kit.

Structure of the teaching kit

Part I consists mainly of information sheets for teachers. Each sheet gives facts on one particular aspect of the disease. A glossary of terms on AIDS is attached to facilitate quick reference on terms that are unfamiliar. Appendix 2 gives a list of materials on AIDS and other blood-borne diseases. Teachers may make use of the materials on the list or other books such as the medical encyclopedia, dictionary of biological terms to find out more about AIDS.

Part II is prepared especially for students. It contains the minimum essential information on AIDS. Each information sheet deals with one aspect of the disease. Most sheets are illustrated to give a better understanding of the topic.

The worksheets for students contained in **Part III** are only experimental. Experienced teachers may like to construct other exercises or classroom activities according to the needs and interests of their students. A key is also provided for the worksheets.

The audio-visual materials are for illustrating the information contained in the Reference Materials for Teachers (Part I) and Information Sheets for Students (Part II). Teachers may wish to make use of the ideas for making posters or designing bulletin boards on AIDS. **Part IV** comprises transparencies which serve illustrative purposes during classroom teaching.

For information : Social Studies and Health Education Section, Advisory Inspectorate, Education Department, Lee Gardens, Hysan Avenue, Causeway Bay, Hong Kong.

For over ten years, the EPES* (People's Health Education) has been developing educational material to meet the needs of the most underprivileged sections of the population. The educational methodology used calls upon the practical experience of participants with a view to integrating the latter into a collective learning process based on games. In this spirit, the EPES produced the game «Learning about AIDS: the responsibility of all», which can be used as it is or adapted, depending on the needs of the group.

Chile

Educational game

"Learning about AIDS : The responsibility of all"

Why play this game ?

- Because AIDS is a fact of everyday life which is affecting our community.
- Because learning about AIDS will help us to protect ourselves and our communities from the disease, and also from the groundless fears concerning it.
- Because a frank and open discussion is necessary to come up with ways of preventing more people from becoming infected with the virus which causes AIDS.

The objectives of the game

- To provide basic information on AIDS.
- To facilitate the expression of ideas, beliefs and myths about AIDS.
- To promote forums for discussion in order to exchange opinions and views on sexuality and AIDS.
- To create awareness of how AIDS is affecting our community.
- To create awareness of the need to prevent this disease.

Why does the board represent a community ?

The AIDS game was deliberately designed like this because AIDS affects every aspect of our community.

People of all ages, origins, occupations and sexual orientations need to know about AIDS so that they can respond on an informed basis to the decisions and challenges posed by the epidemic.

No community is free of AIDS, but each community has the possibility of responding in an effective, caring way, on the basis of solidarity.

By replying to questions on facts and discussing different situations concerning AIDS, the players help to create a caring, well-informed community.

Why is the game played in couples (partners) ?

Because even though much of the information on AIDS is based on scientific fact, most decisions regarding the disease (and ways of preventing it) are personal decisions. More specifically, decisions on safer sex, for instance, are taken by two people in a relationship.

By playing this game in couples and asking the two people in the couple to answer the questions after discussing them, a type of communication is established which can help people to protect themselves. Ideally, the game should be played by people who are partners, which enable them to discuss their fears and desires openly and with mutual support.

**Educacion Popular en Salud - Lutheran Evangelical Church in Chile. For information: EPES, Casilla 360-11, Santiago, Chile. Original in Spanish

Bibliography

General information

- **AIDS in the World - A Global Report.** J. Mann, D. Tarantola, T. Netter. Ed. Harvard University Press, Cambridge, Massachussetts, USA, 1992.

- **AIDS: The Second Decade - A Focus on Youth and Women.** UNICEF, 3 UN Plaza, New York NY 10017, USA, 1993.

- **AIDS & Development.** CAFOD, Romero Close, Stockwell Road, London SW9 9TY, UK.

- **Children and AIDS: An Impending Calamity - The growing impact of HIV infection on women, children, and family life in the developing world.** UNICEF, 3 UN Plaza, New York NY 10017, USA, 1990.

- **Our Children and AIDS - A Guide to Child Survival.** UNICEF Kampala, P.O. Box 7047, Kampala, Uganda.

- **A Children's Guide to Understanding AIDS.** The Committee on Education and Publicity on AIDS and Breakthrough Magazine, Hong Kong.

- **Morning Glory Babies - Children with AIDS and the Celebration of Life.** T.McCarroll, St Martin's Press, New York, USA, 1988.

- **Resource Pack on Sexual Health and AIDS Prevention for Socially Apart Youth.** Ed. AHRTAG, 1 London Bridge Street, London SE1 9SG, UK, 1993.

- **AIDS Prevention: Guidelines for MCH/FP Programme Managers - AIDS and Maternal and Child Health.** World Health Organization, 1211 Geneva 27, Switzerland, 1990.

- **Life First ! - A practical guide for people with HIV/AIDS and their families.** W. Msuya, M. Kudrati, R. Rajani, H. Grosskurth, AMREF Tanzania, P.O. Box 1482, Mwanza, Tanzania, 1993.

- **AIDS Training Manual for Training of Trainers.** Child Welfare Society of Kenya, Commerce House, Moi Avenue, P.O. Box 43982, Nairobi, Kenya, 1993.

- **The AIDS Directory - An Essential Guide to the 1500 Leaders in Research, Services, Policy, Advocacy and Funding.** Buraff Publications, 1350 Connecticut Avenue NW, Washington DC 20036, USA, 1993.

Some Caritas publications

- **Caritas Internationalis and the Global AIDS Pandemic.** Report for the Caritas Internationalis Assembly, May 1991, including the following sections : A Measure of our Humanity - The Church's Response to the AIDS Pandemic : A General Overview of the HIV/AIDS Pandemic; In Retrospect... Caritas Activity in Response to the AIDS Pandemic, 1987 - 1991; Prayers and Reflections on AIDS. Available in English, French and Spanish.

- **Caritas Internationalis Consultation on AIDS - Report of Seminar for Eastern and Central Europe, 15 - 20 April 1991, Cluj, Romania.** Available in English and Romanian.

- **El SIDA : Un Desafio a la Iglesia - Report of Seminar, 7 - 12 January 1990, Santo Domingo.** Caritas Internationalis, SEPAF, SELAC and Caritas Dominicana. Available only in Spanish.

Caritas Internationalis is in the process of finalizing a **training of trainers manual** which may be helpful to church-related organizations which are interested in

preparing their members to serve those affected by the pandemic of HIV/AIDS. The manual contains basic information about the disease, an epidemiological overview of the epidemic, an analysis of the social and development impact of HIV, a discussion of psychological and emotional reactions to the disease.. as well as the basic elements to a compassionate and nonjudgmental pastoral approach to those living with HIV/AIDS.

Caritas Internationalis regional reports

- **SIDA,** Caritas Internationalis **Latin America**, 1988.

- **Un phénomène inquiétant : La pandémie du SIDA - Concertation et réflexion de la zone francophone**, report by Rev. Penoukou and Dr. Goudote, 1989.

- **Consultation on AIDS, Caribbean Zone**, St. Lucia, 1989.

- **Réflexions et propositions à propos du SIDA**, Secours Catholique, Paris, 1990.

- **Consultation on AIDS, Anglophone West Africa Zone**, Ghana, 1990.

- **Caritas Consultation on AIDS in Asia/Pacific Region**, 1991.

Strategies for Hope Series

- **AIDS Orphans: A Community Perspective from Tanzania.** Examines how AIDS affects the family system in rural area of Tanzania. Describes community mechanisms for coping with growing numbers of children orphaned by AIDS.

- **Living Positively with AIDS: The AIDS Support Organization (TASO), Uganda.** Reports on the activities of the first AIDS support and service organization in East Africa. Describes how people with HIV/AIDS and other volunteers provide care, counselling and support for people with AIDS and their families in hospitals and in their own homes.

- **The Caring Community: Coping with AIDS in urban Uganda.** Describes how members of nine small Christian communities in a low-income neighbourhood of Kampala provide care, support and comfort to people with AIDS and their families, and also promote safer sexual behaviour to prevent the spread of the disease.

- **Meetings AIDS with Compassion : AIDS Care and Prevention in Agomanya, Ghana.** Describes the work of St Martin's Clinic in Ghana's Eastern Region in AIDS prevention, and also in the provision of home-based care and support to people with AIDS and their families.

Videos

- **TASO: Living Positively with AIDS** (55 minutes). A two-part videotape on the work of the AIDS Support Organisation in Uganda.

- **TASO: The Orphan Generation** (50 minutes). A video about community-based care and support for children orphaned by AIDS. Includes a 10-minute programme «These are Our Children».

Requests for copies may be directed to : TALC, P.O. Box 49, St. Albans, Herts AL1 4AX, UK

Pastoral resources : HIV/AIDS

- **Prayers and Reflections on AIDS**, in the Global AIDS Pandemic, Caritas Internationalis, 1991. Available in English, French and Spanish.

- **The Churches Speak on AIDS: Official Statements from Religious Bodies and Ecumenical Organizations**, J.G. Melton, Ed. Gale Research Inc., Detroit, Michigan, USA, 1989.

- **The Church with AIDS: Renewal in the Midst of Crisis**, L.M. Russell, Ed. Westminster/ John Knox Press, Louisville, Kentucky USA, 1990.

- **Embracing the Chaos: Theological Responses to AIDS**, J. Woodward, Ed. SPCK, London, UK, 1990.

- **AIDS: Living and Dying With Hope: Issues in Pastoral Care**, W. J. Smith, Ed. Paulist Press, Mahwah, New Jersey, USA, 1988.

The next issue of Children Worldwide will be devoted to Family and Resilience

ICCB's mission

The ICCB, founded in 1948, serves the holistic growth of all children, in a Christian perspective. It gives particular attention to the most deprived, especially disabled children, child victims of drugs, war and the sex trade.

The ICCB constitutes a **network of consultation for research and action**. According to the **needs of children** and drawing upon their capacities, the ICCB develops short, medium and long-range projects. In all its actions, the ICCB takes care to promote **spiritual growth, intercultural awareness and the rights of the child**. It always takes the **child's family environment** into consideration.

The ICCB collaborates with those who work for the **dignity and the best interests of the child** : individuals, associations, universities, non-governmental organizations and intergovernmental organizations. It has **consultative status** with UNICEF, UNESCO, the United Nations Economic and Social Council and the Council of Europe.

ICCB Programmes

• Rights of the child

Defence of the best interests of the child and his/her rights, including their spiritual dimension - Promote the implementation of the United Nations Convention on the Rights of the Child.

• The child and his/her family environment

Lobbying to promote the family and respect for the abandoned child or orphan - Family placement for AIDS orphans - Applied research on the family and resilience.

• Refugee children

Community-based actions for refugees families to counteract the effects of violence - Training for field workers in the psycho-social needs of displaced unaccompanied children.

• Disabled children

Promotion and integrataion of hidden or rejected children with disabilities through a family and community approach - Training in pastoral work with mentally disabled children - Creation of counselling centres for the families of disabled children.

• Sexually exploited children

Action-research on coping strategies of child victims of prostitution - Preventive pilot projects for girl domestic workers - Active participation in international campaigns against the traffic of Asian children for use in the sex trade.

• Street children and drug abuse

Training for street educators - Counselling for street children - Therapeutic community for street girls - Music and art therapy - Dissemination of technical material for street children projects.

• Child-to-Child

An active education method stimulating a sense of responsability in children with other children, their family and community - Dissemination of this method and preparation of activity sheets for animators and reading books for children.

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